YOUTH & DRUGS

AN EDUCATION PACKAGE
FOR PROFESSIONALS

WORKBOOK

UNIT • 5

Intervention & Treatment

Health and Welfare Canada
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UNIT 5:
INTERVENTION AND TREATMENT

WORKBOOK

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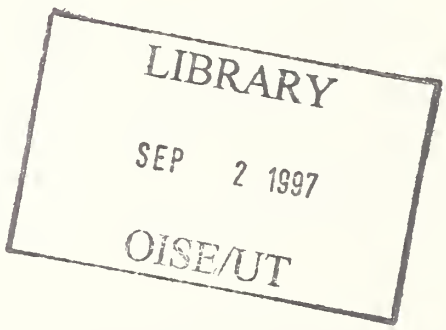

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INTRODUCING UNIT 5

In this Unit, we will describe some approaches to the treatment of young drug users whom you have identified and assessed. It is our best answer to the question "what do I **do** to help them change?" **Not all of you will be willing or able to undertake delivery of a full program of "youth drug treatment", nor is it appropriate that all youth-involved professionals do so. However, we want to give all practitioners a file of useful ideas on drug use intervention to borrow and adapt to your own situation. We will present them in the form of an integrated treatment model, based on the practices of ARF's Youth Clinic, but they can be used, in whole or in part, by almost anyone who works with youth.**

The ideas and skills of Unit 5 are based on socio-behavioural counselling techniques, and derived from social learning theory. The basic operating assumption is that **drug use is learned behaviour, triggered and maintained by specific events and feelings**. As such, it is amenable to change. The socio-behavioural approach offers several advantages:

- it is the basis for the most effective set of methods for treating young drug users that we currently know of;
- professionals who work with youth are likely to be familiar with its core concepts;
- its methods can be integrated with other approaches to intervention;
- its component skills are flexible enough to be used with youth at any stage of the continuum of drug involvement, and in almost any setting, from individual counselling situations to residential treatment programs.

The goals of Unit 5 are:

Goals: Unit 5

- to teach you how to help young drug users set goals for change in drug use and other life areas;
- to acquaint you with the "**A-B-C**" method by which clients can analyze their drug use patterns;
- to empower you in your work with young drug users by describing effective interventions and strategies to achieve change;
- to introduce you to an array of techniques which you can use to help adolescents develop alternatives to drug use.

The emphasis throughout this Unit is on **what to do** and **how to do it**. There is no simple formula for success. But you will be able to move a long way forward if you use some of these techniques in your work with young drug users.

Before continuing with this Unit, we would like you to do ACTIVITY 5.1 on page 5-16.

EXPECTED LEARNING OUTCOMES

When you have worked your way through this Unit, you will be able to:

- ☐ **describe** and **practise** a 5-stage process of intervention into and treatment of youth drug use, as follows:
  - goal setting
  - **ABC** analysis of drug use
  - interventions and alternatives
  - relapse prevention and management
  - aftercare.
- ☐ **facilitate** the setting of goals for change in drug use and other life areas;
- ☐ **work** with clients who express either abstinent or non-abstinent drug use goals;
- ☐ **explain** the idea of the "**ABC**" analysis to an adolescent client;
- ☐ **name** the three components of the "**ABC**" analysis of drug use, and **elicit** information about each from your clients;
- ☐ **use** the "**ABC**" analysis of drug use to help clients understand and change their use patterns;
- ☐ **use** a variety of tools and self-management techniques to help clients gain control over drug use;
- ☐ **work** with clients on an array of techniques which you can use to help adolescents develop alternatives to drug use;
- ☐ **prepare** clients for the possibility of relapse, and **help** them respond to it positively if it happens;
- ☐ **initiate** aftercare procedures;
- ☐ **explain** the importance of program evaluation, and its contribution to the quality of service you provide;
- ☐ **carry out** evaluations of individual client progress and general program success.

After you have completed this Unit, we will ask you to return to this list and check off the learning outcomes you have achieved.

PREVIEW OF TOPICS TO BE COVERED IN UNIT 5

In its bare bones, the process of treatment consists of:

(1) setting goals for change in drug use and related behaviour,

(2) implementing interventions that facilitate the achievement of those goals.

The Table of Contents of this Unit lays out the components of our approach to adolescent drug use treatment, and indicates the order in which they should be undertaken, as follows:

- **Setting goals for change** with respect to drug use and other life functioning areas is the starting point for you and your client.

- **The "ABC" analysis of drug use** presents a practical tool for establishing the pattern and dimensions of drug use, and for assisting your client to specify the changes s/he wants to make.

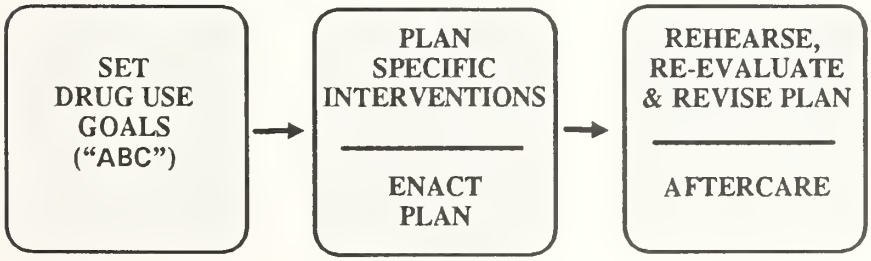
- **Interventions to achieve drug use goals** includes discussion of: strategies to interrupt drug use, self-monitoring, and methods of dealing with drug cravings, with drug refusals and with relapse.

- **Strategies to achieve alternatives to drug use** addresses issues such as problem solving, negative thought patterns, social skills, leisure skills, vocational skills, wellness and family relations.

- **Aftercare** describes the ongoing involvement you should have with your client, once drug use goals have been achieved and initial improvement in functioning in other life areas has been achieved.

- **Evaluation** presents strategies for monitoring and evaluating progress and achievements.

The Unit will take you step by step through the main elements of intervention and treatment, as shown in the schema below:



ESTIMATED WORK TIME AND STUDY TIPS

The time it will take you to work through Unit 5 is difficult to estimate, as it depends on your purpose in undertaking the material. Since comprehensive drug treatment is beyond the capacity of many professionals who will take this course, Unit 5 is, in a sense, optional: it is designed primarily for those who can contribute to the delivery of a multi-faceted youth treatment service.

In fact, however, we believe it will be a valuable resource for all practitioners. The ideas can be adapted for work with young drug users in any setting, at any depth, in whole or in part. You may even find that many of the techniques discussed are applicable to youth with problems other than drug use. **We recommend that all students of this course read through the Unit, and familiarize themselves with the contents.**

A quick read-through will take about 3-4 hours. Careful study of the entire Unit, including videotape and activities, may take as much as 25-30 hours. If you choose to develop some or all of the ideas in the Unit for active use in your facility, you may wish to spend more time than that.

We strongly recommend that you do all activities. Educational research has shown that active participation of the student in his or her own learning process is more effective than passive reading, in terms of both comprehension and retention.

Have your VCR and tapes ready!

You should begin Unit 5 by watching the fifth videotape in your course package, the story of "Chris". It is a little different from the previous case studies you have viewed, in that it is a single story, told without breaks and without guidance from an on-camera presenter, and it is shown entirely from the point of view of the professionals. However, the structure of the course is embedded in the story: it moves from issues of adolescent development and drug use, through those of identification, assessment and intervention. You should use the tape as a summary and review of the concepts you have learned in the course.

You can refer to your Book of Readings either now or when you have finished the Unit.

Supplementary reading on the issues of this Unit can be found in the last two chapters of your Book of Readings: an overview of treatment issues in the chapter by Wilkinson and Martin, and an example of family intervention in the chapter by Quinn, Kuehl, Thomas and Joanning.

The Nova Scotia Commission on Drug Dependency has just published an excellent resource manual for use in the treatment of adolescent drug abuse, entitled *Choices*. In seven units, this package presents facilitator's notes, visual aids and handout masters to be used in a comprehensive program of rehabilitation and lifestyle re-education. The material it contains is an excellent complement to this Unit of Youth and Drugs, for professionals engaged in active treatment.

Section 1: SETTING GOALS

Goal setting is the starting point of treatment. The first two Sections of Unit 5 will teach you how to help each client identify and articulate goals for change, both in drug use and other life areas. In this Section, we will focus on:

- *an exploration of possible drug use goals,*
- *how to work with clients who choose non-abstinent drug use goals,*
- *goals in other life areas.*

1.1 Drug Use Goals

In Unit 4, we discussed the need for an assessment of both drug use and other life problems that are affecting the young drug user, in order to make preliminary decisions on goals for treatment and initiate (or recommend) a course of action. In the treatment phase of your relationship, you will start from the information established during assessment, and work with the youth to further explore and concretely define goals for change — in relation to both drug use and other life areas. It is usually best to start by defining drug use goals.

Please refer to the Goals Assessment form, page 4-75, and review or re-administer to your client.

STEP ONE is to elicit a detailed, but still open and non-judgemental discussion of possible goals for a client vis-a-vis his/her drug use. You will be building toward specific objectives for change: for example, from "fixing up my life" to "cutting out weekend binges and stopping all use of tranquillizers".

Techniques for setting concrete goals are discussed in Sections 2 and 3 of this Unit.

The occasional young drug user may express the goal of achieving abstinence from all drugs, but **ambivalence or resistance** to quitting drug use is more usually the rule - e.g. "cutting down", "cutting out only cocaine", "just drinking", etc. It is important to be realistic: few adolescents will opt for total abstinence **at the outset of treatment.** If you insist on it, you are likely to spark resistance, distance and distrust, and to risk the client's disengagement from the possibility of counselling or treatment. Your primary concern at this stage is to keep your client talking. Start with whatever goal s/he can accept, and work first towards "harm reduction", then ultimately to abstinence. A progression of this kind is described in the Unit.

Where did this strategy appear in the videotaped story of "Chris"?

COUNSELLOR'S TIP

Once an adolescent has experienced control over one substance, s/he will often become more receptive to the idea of extending this control to include other substances. Insisting upon total abstinence at the beginning of the change process can drive him/her out of treatment before it properly begins.

STEP TWO is to gain some understanding of goals that involve non-abstinence. Here are four of the most common reasons given by adolescents for choosing non-abstinence:

"It's not hurting me."

- The use of a particular drug may be seen as "experimental", or, because of its short period of regular use, there may be few negative consequences of use.

"Old age is the pits anyway — I'd rather die young."

- Normal adolescent feelings of present-orientation and invulnerability make it difficult for the client to make life-long plans for **any** pattern of use, or to adequately evaluate the long-term physical, social or psychological consequences of drug use. For youth, "long term" may mean 1-2 weeks!

"I **can't** *go to a party and not drink — I'd be the only one."*

- Peer and other environmental pressures to conform with what others are doing make abstinence seem hard or unattractive.

"I couldn't stand school if I wasn't high."

- Substance use may be a response to stressors from which the youth feels unable to escape. S/he may feel unable to give up drug use until s/he has some alternative way of dealing with these stressors.

Where there is a discrepancy between a youth's drug use goal(s) and what you see as necessary or best, you will need to exercise caution in order to resolve the potential conflict constructively. Refrain from "telling the client what to do", which is particularly ineffective with adolescents. Instead, try to motivate him/her over time to believe in and actively work towards appropriate goals, as discussed in this section. Where you and your client disagree, you should focus first on those goals that are agreed upon, returning later to discuss those in dispute.

COUNSELLOR'S TIP

Always let your client know when his/her goals seem less than ideal, but in a non-challenging way, e.g. "Based on your assessment results and my previous experience, I think you would have better luck changing your situation if you gave up drugs altogether. But what you want is important to me. So let's start from there and see how it goes. You can always change your goal later if things aren't working out."

1.2 Non-Abstinent Drug Use Goals

Non-abstinence is usually presented in one of three forms:

- the client's goal is to become temporarily abstinent, but not necessarily to remain so;
- the client wishes to achieve and maintain abstinence from some but not all drugs;
- the client rejects non-abstinent goals in favour of "cutting down" or some other compromise.

We will now present strategies for re-directing these client positions.

Time-Limited Drug Use Goals

In order to avoid conflict about ultimate drug use goals, focus first on planning with the client to **bring his/her drug use under control in the present**. The short-term goal might be modest: abstinence for an evening, a day, a week or a month. Whatever it is, if it is realistic (i.e. this particular client can achieve it with a reasonable effort) and if it is achieved, it opens the door to more ambitious goals, leading ultimately to abstinence.

Almost any goal can serve as a point of entry.

COUNSELLOR'S TIP

A good "first goal" is often for the client to achieve abstinence on the day of his/her appointment with you; then, on that day and the preceding day; then for three days, and so on, as slowly as necessary.

At each meeting, you should review the progress, and revise goals. The client who has achieved a couple of days of abstinence may be ready to set a goal of abstinence for a week. The client who has achieved a month's abstinence may see three months or six months or a year as a realistic horizon. During this time, the client will be gaining positive experiences of being drug free, and confidence in his/her ability to control drug use. Be sure s/he understands that these are big accomplishments, and credits him/herself. Even small victories will contribute to the inclination to continue toward an abstinence goal.

It is likely that Theresa will find it easier to control her drinking, given her success with other drugs.

Even clients who agree to aim for total abstinence may benefit from working on time-limited drug use goals. However good their intentions, giving up drugs can be a big loss and an enormous undertaking for a teenager. Time-limited drug use goals break it down into more manageable bits.

COUNSELLOR'S TIP

- Goal setting will be affected by the client's "stage of change" (see Unit 3). In pre-contemplation, the client will be unwilling to set goals at all. In the contemplation stage, s/he may set them, but not act. You will get your best results if the client is in the action stage.
- If a client cannot attain abstinence, it is still of enormous benefit for you to help him/her experience being drug-free as often and as long as possible.

Partial Abstinence Goals

With youth who are prepared to set an abstinence goal for particular drug(s) but not others, you should proceed as described above with time-limited goals for the drugs of agreed concern. Once the client begins to gain control over one drug, s/he is likely to be more prepared to generalize to others.

It is important to monitor the use of the drugs that a client continues to use:

- If use is decreasing, the client may be able to generalize control over drug use, and set goals for the drugs that s/he was previously unwilling to consider.
- If use of another drug is increasing while the youth is making progress with a designated drug, consider the possibility that the client is engaging in **drug substitution**. Drug substitution is clearly a cause for concern. Where it has been identified, you should attempt to motivate your client to try to control the drug that is on the increase as well.
- If other drug use is continuing in a stable pattern and the client is **not** making progress towards abstinence from the designated drug, you will need to explore the relationship among all the drugs being used. The **ABC** analysis of drug use (see Section 2 of this Unit) and self-monitoring exercises (Section 3) can be used to help the client see how the use of one drug may make it more difficult to stop the use of another. (It is possible, for example, that one drug triggers the use of another.)

Harm Reduction Goals

Clients who, contrary to your advice, set goals that involve on-going drug use can create considerable dissonance. On the one hand, you have to deal with the frustration of the client's refusal to follow advice, and reassure yourself that you are not "enabling"[1] the client to continue a maladaptive pattern of drug use. On the other hand, you must realize that the process of resolving drug use is a gradual, evolving one, not unlike the process of problem development that preceded it.

The appropriate strategy here is to persevere with the client, attempting to work with him/her on a **harm reduction** basis. The object is to help your client hold the negative consequences of use to self and others to the lowest possible level. If the client intends, for example, to continue drinking, your only course of action may be to explore the potential for harmful consequences, and to work toward safety precautions such as not driving while under the influence. Or, in the case of a cocaine user, you may be forced to work toward a switch from needle use to inhalation, in order to reduce the potential for harm. This is **not** the same as condoning the drug use, but a necessary and beneficial stage in working with a user who will not consider non-abstinence.

Given that Danny's drug of choice is inhalants, what harm reduction goal might be appropriate?

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1 "Enabling" is a term borrowed from the widely publicized treatment model of Vernon Johnson, which suggests that people in a drug user's life may unwittingly facilitate use by protecting and excusing him/her from the consequences of his/her actions.

COUNSELLOR'S TIP

It is important to find out whether treatment goals are consistent with those of significant others, especially family, and of other systems involved with the client, such as school, group home or probation officer. Although goal consistency is desirable, it is not always possible. Together, you and your client should identify goal discrepancies and possible consequences of conflicting goals, so that they can be anticipated and dealt with. You may be called on to advocate on behalf of the client where agreement is not forthcoming.

Controlled Drinking Goals

Although we advocate abstinence from all drugs, including alcohol, as the appropriate goal for minors, you will be called on to consider controlled consumption of alcohol as a goal for those who are of legal age. The following factors should be considered in determining the appropriateness of a controlled drinking goal:

- **Level of alcohol use:** Early stage drinkers, whose history of alcohol use is short, who do not drink heavily, and who are not physically dependent on alcohol, are in the best position to consider moderate drinking as a goal.
- **Physical health:** Though adolescents are unlikely to have developed serious chronic health problems as a result of their drinking, they may have some pre-existing medical condition that could be made worse by alcohol use, e.g. diabetes or a psychiatric condition. In these instances, medical advice is advisable, and abstinence is the appropriate use goal.
- **Behavioural health:** If alcohol is associated with dangerous, violent, or risk-taking behaviour, abstinence is strongly advised.
- **Family history of alcoholism:** Clinical experience as well as research studies have documented the familial nature of alcoholism. Whether because of "nature" or "nurture", or a combination of both, children in families where there is parental substance abuse are at greater risk of developing a problem themselves. There is no way of predicting whether a child in an alcoholic family will go on to repeat the pattern, but you should advise your client of the increased risk s/he is facing.

  Furthermore, it will be more difficult for a youth to achieve a goal of abstinence, or even moderation, if one or both parents are actively abusing alcohol/drugs. This again points to the importance of family assessment and possible marital/family therapy.
- **Environmental supports:** You need to determine the full range of environmental supports (from family, peers, school, community) that are available to your client, and assess how significant others will react to a moderate use goal. Goal conflict is a distinct and stressful possibility, which weighs against this choice of goals.

Counsellor Collin Cardinal supported a controlled drinking pattern for Cindy. Given the circumstances, do you agree?

REMEMBER:

- Work with your client to identify an immediate drug use goal that is realistic for him/her;
- Don't get caught in conflicts about abstinence versus non-abstinence as the best long-term goal — focus on the present;
- Build incrementally on initial goals until your client has established control over his/her substance use behaviour;
- Be patient — this process may take some time!

Before continuing with this Unit, we would like you to do ACTIVITY 5.2 on page 5-17.

1.3 Goals in Other Life Areas

For many young drug users, problems in life areas such as relationships, finances, the law, emotional and physical health, and school or work have preceded or resulted from their drug use. These problems need to be addressed, and goals for change need to be set.

Review the use of the DUSI, pages 4-63 to 4-74.

In Unit 4, we presented the DUSI as a guide for investigating the general situation in these life areas. The **ABC** analysis of drug use (to follow) will help you to define goals for change in those life areas which may need to be achieved in order for your client to achieve drug use goals.

Setting goals for improved life functioning leads directly to the set of interventions we call "alternatives to drug use" (Section 4 of this Unit).

1.4 Summary: The Functions of Goal Setting

Goal setting contributes to treatment in three principal ways:

- **It translates the findings of assessment into clearly defined objectives for change,** gradually starting with the short term and progressing toward the long term..
- **It establishes an agreement between client and counsellor about what you are doing together.** Coming to an agreement on goals will require a process of negotiation, clarification and sometimes compromise, and it may take considerable time. Goals cannot be imposed by you or any other "wise" adult. Your client will not apply him/herself to a goal that s/he does not truly share. Similarly you will not be able to work with a client on a goal

you believe to be inappropriate (e.g. quitting school in order to avoid drug-taking friends).

- **Goals give the client and practitioner "bench marks" from which to monitor progress.** Although we have discussed goal setting as "step one" in the treatment process, in fact the course of treatment is not linear. It is a series of stops and starts, successes and relapses — and so, goal setting is continual. Time and again, you will assess your client's progress, and set new goals as old ones are achieved. At each meeting, you should begin by reviewing goals and progress. When no progress is being made, you should explore impediments. This may involve revising current goals, or developing different intervention strategies.

  New or previously undetected problems may emerge during the course of treatment, implying new goals. It is not uncommon for problems that were masked by drug use to surface, or for problems to arise as a direct consequence of withdrawing from drugs, either physical, social or emotional. It is important that each one be dealt with as it comes up.

Goal setting is both a stage and a recurring technique.

COUNSELLOR'S TIP

In order to avoid feeling overwhelmed by the number and variety of goals that you and your client identify, it is important to prioritize them or to restate them as smaller achievable objectives. Some goals may be put on the "back burner" while a smaller number of key goals are being addressed. Priorities may change as more urgent problems arise. The following are guidelines for selecting priority goals:

- Begin with goals that the client is most willing to work on;
- Focus on objectives that are relatively easily and quickly achieved, to reinforce success;
- Attend quickly to goals that address crisis issues, e.g. medical emergencies, housing and financial needs, etc.

For Danny, Theresa and Chris, formulate one small first goal, in line with these tips.

Before continuing on to Section 2, we would like you to do ACTIVITY 5.3 on page 5-18.

ACTIVITY 5.1

Do you have any experience in drug treatment? YES ☐ NO ☐

If yes, what are the limitations you perceive in the system or method you were using, and what do you hope to learn from this Unit on intervention and treatment?

If no, describe your goals for undertaking this Unit on treatment.

ACTIVITY 5.2

Review the dramatized case studies of Cindy, Danny, Theresa and Chris. Compare and contrast the environmental supports available to each one. How well did each professional assess and use these supports?

CINDY:

DANNY:

THERESA:

CHRIS:

ACTIVITY 5.3

Think of a major goal for change in your own life. State it both generally and in specific, behavioural terms (e.g. I will see more of my friends: I will call Mary tonight).

Is this goal consistent with the desires of significant others in your life?

If not, what consequences should you expect if you move towards it?

Can you prioritize the components of your goal?

Are there changes in other areas of your life which would support this goal?

Section 2: THE ABC ANALYSIS OF DRUG USE

In this Section, we will describe the key technique we recommend for analyzing a youth's drug use pattern, and for setting goals — the **ABC** *(or "functional") analysis. The* **ABC** *analysis is an immensely practical tool, which will provide you with:*

- *a clear picture of your client's substance use behaviour;*
- *insight into why s/he is using;*
- *a basis for setting goals for change in drug use and other life areas;*
- *a method of analyzing specific episodes of drug use.*

2.1 The Basic Format

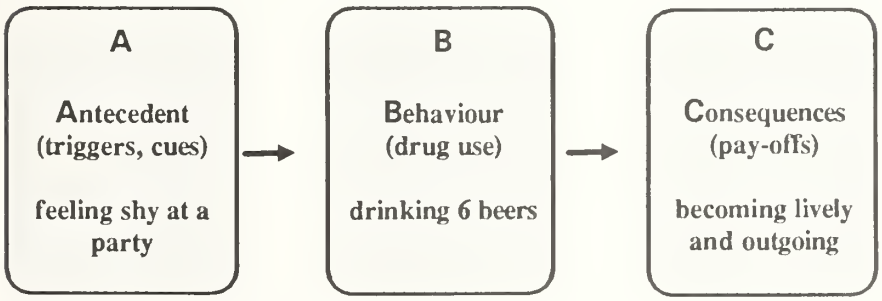
The **ABC** analysis is derived from social learning theory, which views drug use as a **learned behaviour** triggered by **specific cues** and reinforced by **specific pay-offs. The triggers, or cues, are the** Antecedents — designated "**A**" in the **ABC** analysis diagrams which appear in this Unit. The drug use is the Behaviour that you are trying to change — designated "**B**". The reinforcing pay-offs, or desired results of the drug use, are the Consequences — designated "**C**".

Quite literally, drugs "do something" for the user. The ABC exercise will tell you what that is.

According to this model of behaviour, **drug use persists because of Antecedent conditions that predispose the adolescent to use a drug for its desired effects, or reinforcing Consequences.** In other words, a young person uses drugs because there is a drug effect that s/he likes. The desire for this effect is sparked by particular Antecedent situations (e.g. fights with parents), feelings (e.g. depression) or thoughts (e.g. "I'm a failure") which then lead to drug use and its desired Consequences or pay-offs (e.g. feeling better, or forgetting the fight). **This sequence is referred to as the functional pattern of drug use.**

Can you think of at least one trigger and one pay-off for Theresa's drug use?

Example:



In this example, the function served by the client's drug use (drinking beer) is to make him/her feel better and more outgoing at parties. The basic format may appear simplistic, but its usefulness in treatment is enormous — as you will see.

COUNSELLOR'S TIP

Some of the information you will get as you proceed through the steps of an **ABC** analysis may be disturbing and powerful for the struggling teenager. S/he may be sharing, or discovering, "hidden truths" about him or herself, for the first time. You should be ready to support the emotional consequences.

Equally possible, the use of the **ABC** model may be a source of relief to the youth, because it helps to simplify and explain aspects of his/her life which have been chaotic and overwhelming.

2.2 When to Use the ABC Analysis

The **ABC** analysis is useful throughout the intervention and treatment process. You will find it particularly relevant for the following:

- goal setting;
- analysis of specific episodes of drug use;
- communicating the nature of the youth's drug use to significant others, especially family members.

Use the ABC for goal setting:

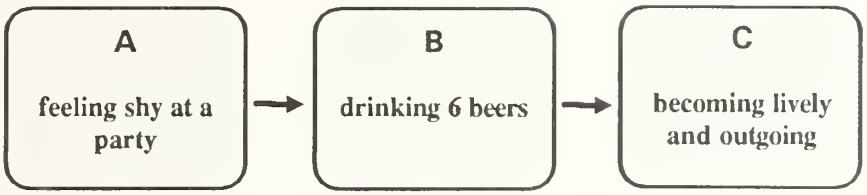
If a young drug user cannot immediately formulate goals for controlling drug use, an **ABC** analysis is the best bridge to lead him/her from assessment to action. The **ABC** helps most clients to clearly see their patterns at the outset of treatment, and thus focus on specific goals for change in drug use and other life areas. Treatment goals should address both the triggers (antecedents) and pay-offs (consequences) of drug use.

If they know exactly when and why they use, they will be better able to imagine alternatives.

- **Goals directed towards antecedents:** the objective here is for the youth to avoid or eliminate antecedent conditions that trigger drug use, or develop a non-drug-using response to an antecedent situation.
- **Goals directed towards consequences:** the objective here is for the youth to develop alternative ways to achieve the reinforcing consequences of drug use.

Goals developed by means of the **ABC** to these ends will comprise a detailed and individualized treatment plan for each client.

On page 5-19, we introduced this example:



In this example, let us suppose that you and your client have agreed on a drug use goal of reducing or eliminating alcohol. Concrete goals which might emerge from an **ABC** analysis are:

- for the youth to avoid the **A**ntecedent trigger by leaving the party or not going in the first place;
- for the youth to make a non-drug-using response to the trigger by looking for a friend at the party (this is the new **B**ehaviour);
- for the youth to develop alternative ways of achieving the desired **C**onsequence (being outgoing at a party) by exploring social skills, such as starting and maintaining conversations.

A "goal assignment" exercise used in an Ontario day treatment program appears in the Client Activity Appendix, page 5-89. This assignment will help the client think about changes s/he must make to achieve long-term drug use goals, and to focus on those that are a priority.

You may also want to make use of the Treatment Goal Assessment form, page 4-77.

Use the ABC for analysis of episodes of drug use:

Drug using episodes that happen while you are working with a young person should be analyzed according to the **ABC** format, so that both of you can understand the function of each drug use and work out strategies to avoid repeat occurrences. This way, a client can learn from an episode of use, instead of merely feeling bad about it.

Case Example

A client (Jake) reported a night of solitary cannabis use, triggered by his father criticizing him for continued unemployment. The two argued, and Jake stormed out of the house and smoked three joints while walking the streets. The consequence was that he was able to escape from his anger and hurt, and gain relief from the frustrations of not finding work. In their next session, Jake and his counsellor focussed on strategies for "taking time out" from arguments with dad, and for dealing with the stress and frustration that such arguments precipitated. After exploring a variety of options, Jake was able to identify two alternative courses of action which were realistic for him and would deliver an acceptable consequence:

- leave the house and get a physical workout — jog or use the punching bag at the local gym,
- call his girlfriend, who was supportive and sympathetic.

Use the ABC for communicating with significant others:

Parents, siblings, spouses, friends or other professionals involved with the client may gain new insight into the client's drug use if they understand its functions. Discussing the **ABC** analysis with the family (with the client's permission) can be an effective way to involve them in the treatment in terms that are concrete, and make sense of the adolescent's behaviour. You can also encourage family members to support the youth as s/he discovers and deals with the antecedents and consequences of drug-taking behaviour, and explores constructive alternatives. The **ABC** may also help them see how their own behaviour functions as one of the triggers that sets off and maintains the drug use.

2.3 PREVIEW: Steps in Doing an ABC Analysis with a Client

PRELIMINARY STEPS:

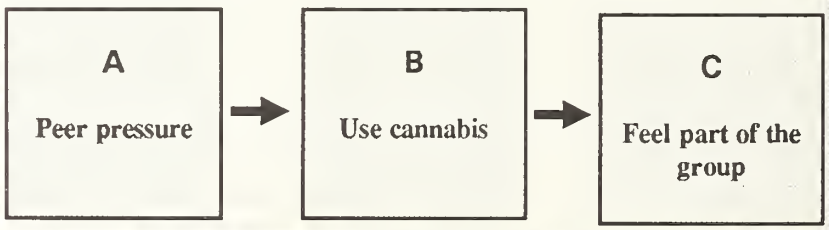
- Define and describe the concept of functional analysis to the client.
- Define and describe each component: **A**ntecedents, **B**ehaviour, **C**onsequences.
- Be prepared to write out the information graphically for the client, using paper, blackboard, flip chart, etc. Give the client a copy of his/her **ABC** and keep one for your records.

STEP 1. Establish the drug use **Behaviour** (details in Section 2.4).

STEP 2. Identify the **Antecedents** of drug use (details in Section 2.5).

STEP 3. Identify the **Consequences** of drug use (details in Section 2.6).

The result of this process is a detailed picture of the pattern of drug use by a particular adolescent, which can be summarized schematically as in the example below:



A more fully developed example of a typical **ABC** analysis appears on the next page.

SAMPLE ABC OF OVERALL DRUG USE IN PAST 3 - 6 MONTHS

ANTECEDENTS	BEHAVIOUR	CONSEQUENCES
	1. ALCOHOL USE	
— bars — friends	— 6 to 10 beer a day or 5 ($1^1/_2$ oz.) drinks — use 5 days a week — earliest use - 5:00 p.m. — 80% use with others	— increased confidence in social situations, more talkative, acceptance by peers, increased status in peer group
	2. CANNABIS USE	
— feeling down — feeling guilty — arguments with family	— 3 grams (10 joints) a day — use 5 days a week — earliest use - 1:00 p.m. — 50% use with others	— feels up — escapes family arguments
	3. LSD USE	
— being downtown — free time — criminal activities	— 6 to 8 hits per day — use 3 days a week — 1 use per day — earliest use - 4:00 p.m. — 80% use with others	— excitement — change of pace — courage
	4. VALIUM USE	
— negative thoughts, e.g.: "I'm worthless", "I'm not good enough to get a job".	— 24 pills per day — 2 uses per day - 6:00 & 8:00 p.m. — use 4 days a month — 25% use with others	— decreased negative thinking, down feelings and guilt, relaxation

2.4 STEP ONE: Establish the Drug Use Behaviour

Begin by establishing the client's drug use pattern, according to the following headings:

- type of drug,
- mode(s) of administration,
- frequency of use,
- quantity.

Refer to column 2 of the **ABC** sample above for an abbreviated model. In order to help the youth to self-disclose, assume s/he uses.

Type of Drug

When discussing drug use behaviour, it is important to ask the client to be as specific as possible about the pattern of use for all drugs, so you will know exactly what you are working on, and so there are no "secrets". Focus on the major drugs used within the past 3-6 months. Have the client discuss each one separately, in order of priority as s/he sees it, and list these in chart form as shown on the previous page.

> **COUNSELLOR'S TIP**
>
> A client may claim that a drug such as tobacco, cannabis or alcohol is not a problem, and reject abstinence. It is useful to have him/her describe the pattern of use for such a drug anyway. Once the use pattern is seen in terms of the **ABC** model, the client may be more willing to acknowledge that a problem exists (or conversely it may become clear to you that use of these substances is not, in fact, problematic).

Mode(s) of Administration

For some drugs there is only one mode of administration — e.g. alcohol is taken orally. For other drugs there are various modes — e.g. cannabis can be inhaled by smoking or taken orally. Cocaine may be smoked, snorted or injected intravenously. (See Section 1.1 of Unit 2, "Youth Substance Abuse," for a more thorough discussion of modes of administration.)

Frequency

It is necessary to establish how often a drug is taken within a particular time frame. The question can be put in terms of "number of drug-taking occasions" per day, per week, per month or per year. Usually there is some fluctuation, which can be recorded as a range from minimum to maximum frequency. Note special patterns, such as time of day or fluctuations during the week (e.g. drug use is often more frequent on the weekend).

Quantity

To discover how much of a particular drug a client uses per drug-using occasion, establish the "typical dose", as discussed in Unit 2. Here is a quick review:

- alcohol: standard drink;
- cannabis: number of joints, by weight in ounces or grams;
- pills: number of pills, noting the strength of each;
- LSD: hits or number of units;
- cocaine: weight in grams.

By multiplying the frequency of use by the quantity per use, you will establish roughly how much of a particular drug is being used.

COUNSELLOR'S TIP
Questions to ask about drug use behaviour:

- How much is used?
- How often: (a) days per week?
  (b) times per day?
- How is the drug administered?
- Proportion of use with others and alone?

2.5 STEP TWO: Establish the Antecedents of Drug Use

After the pattern of use of a particular drug has been established, identify the Antecedents, or triggers, for its use. Be sure to do this for each drug separately.

Antecedents may be found in any area of a client's life. Here are some typical examples:

- **social:** parties, hanging out with particular friends;
- **situational:** a drug offer, a fight with parents, being bored, celebrations, getting up in the morning;
- **physiological:** pain, withdrawal symptoms, insomnia;
- **emotional:** anger, depression, confusion, anxiety, happiness;
- **cognitive:** painful memories, lack of confidence, negative thoughts.

Can you name three triggers for Danny, and for Chris?

Most adolescents have a multitude of antecedents to their drug use. Usually it is sufficient to identify those that are most often associated with use, and those that are most powerful in triggering use. About 3-5 important triggers should be identified for each drug used.

It is useful to be as specific as possible. In other words, identify the **particular** friends that trigger drug use, **which** celebrations are typically associated with drug use, the **specific** withdrawal symptoms or the **nature** of the painful memories associated with wanting to use, etc.

COUNSELLOR'S TIPS

- The use of one drug may be an antecedent for the use of another drug. This is often the case with multiple drug users. For example, alcohol use may be triggered by cocaine use when the user is coming down and wants to "mellow out".
- Since drug talk is often a trigger for adolescents, AA can be the wrong strategy for some.

A useful tool in identifying a client's trigger risk situations is the Inventory of Drug-Taking Situations (IDTS — see Unit 4, p. 4-61). This 50-item self-report questionnaire provides a profile of the client's past drug use with reference to eight potential antecedent or trigger situations:

- negative emotions,
- physical discomfort,
- pleasant emotions,
- testing personal control,
- urges and temptations to use,
- conflict with others,
- social pressure to use,
- pleasant times with others.

The IDTS may be used to establish the antecedents of drug use for each major drug used by a client. An example of one client's risk profile for cocaine use is shown below. This client is most often triggered in "positive affect" situations, whether alone (feeling happy, relaxed) or with others (having a good time with friends, celebrating).

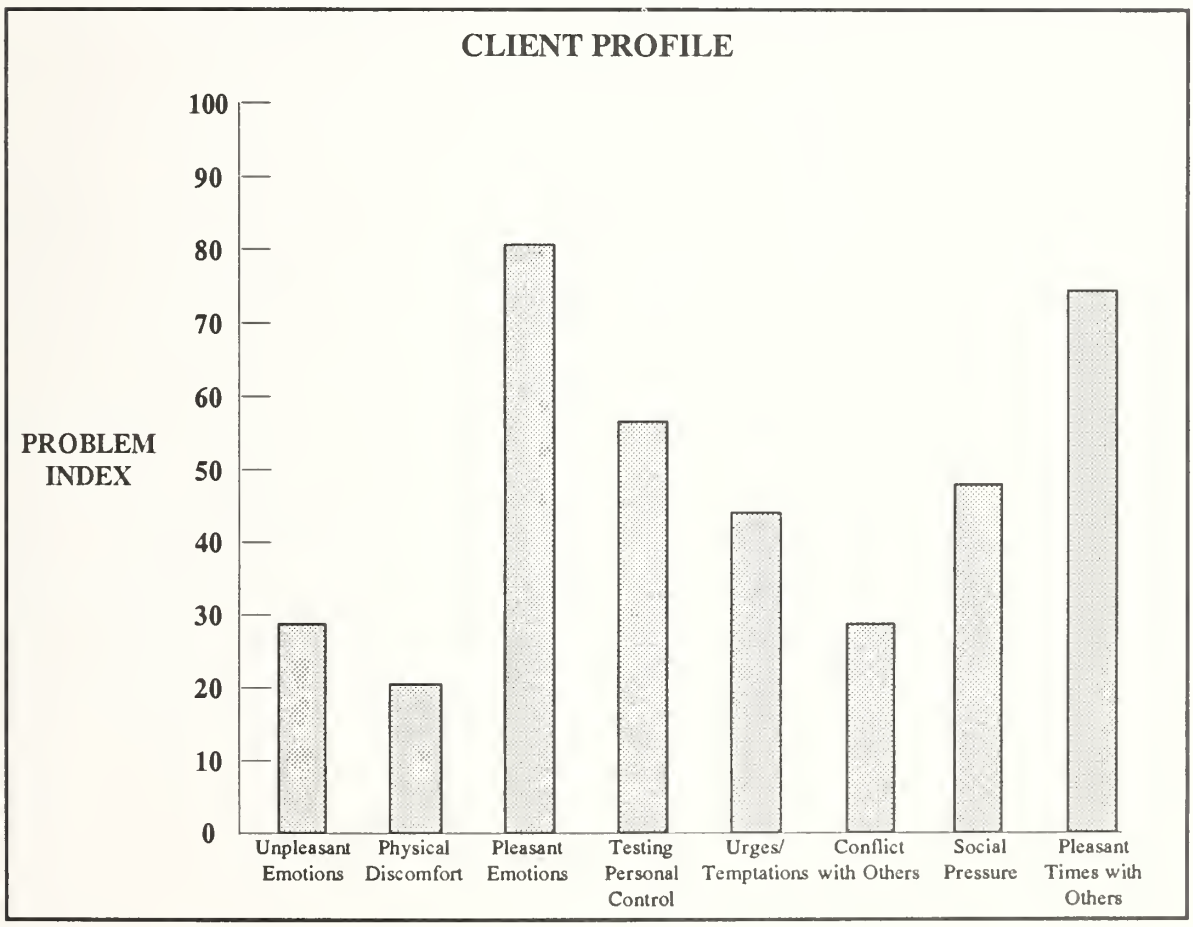


Fig. 5.1: *Client Profile, based on use of the Inventory of Drug-Taking Situations.*

The specification of triggers for each client will lead you to develop unique treatment strategies, matched to the results of his/her **ABC** analysis. Such strategies will be discussed in the next Section of this Unit.

It is well established that children of alcoholics and those who have been physically, sexually or emotionally abused often use drugs to cope with memories and flashbacks, as well as feelings of worthlessness. For that reason, you may uncover "historical" roots for current antecedents: e.g. past sexual trauma may underlie immediate anxiety about sexual relations, which in turn can be a frequent trigger. You may need to arrange for long-term therapy to resolve the feelings around the trauma, while continuing to address the immediate goal of handling sexual encounters more satisfactorily in the present.

COUNSELLOR'S TIP

Questions to Ask About Antecedents (Cues or Triggers):

Social:	Who are you with? How are you relating to people you're with?
Situational:	What situations are you in? i.e. where are you, what do you see and hear?
Cognitive:	What are you thinking about? What are you saying to yourself?
Physiological:	How do you feel physically? e.g. sensations, aches and pains.
Emotional:	How do you feel emotionally?

Before continuing with this Unit, we would like you to do ACTIVITY 5.4 on pages 5-31.

2.6 STEP THREE: Establish the Consequences of Drug Use

A youth who actively seeks your help is probably doing so because the negative consequences of use have begun to outweigh the **positive** consequences. There are many negative consequences of adolescent drug use, from parental disapproval to trouble with school and other authorities, to feelings of being out of control. However, if drugs had **only** negative effects, kids wouldn't use them. At least at the beginning, the pay-offs probably have the most impact on the young client's life. In the **ABC** analysis, your principal focus should be on discovering the positive consequences of use, since it is the desirable drug effects that reinforce and maintain drug use.

Notice the effect on Chris of Paul Golding's discussion of positive consequences (videotape #5).

COUNSELLOR'S TIP

It is often a surprise and a refreshing change for an adolescent to find that s/he can talk to an adult about positive drug effects. Most adults deny the reality of those feelings and experiences, and thus discredit themselves in the teenaged client's eyes. The counsellor who explores what a client **likes** about drug use, in neutral non-judgemental language, offers a special understanding by acknowledging and validating the reality of his/her feelings. Even "hard cases" may find this approach engaging.

Negative consequences are a useful tool in addictions counselling because they can be powerful motivators for the client to stop drug use. Many of the classic negative consequences, such as ill health and debt, can be slow to develop and may be difficult for teenagers to take seriously as possibilities for themselves. Nevertheless, a listing of negative consequences can be helpful in assisting the client to see the total "balance sheet" of drug use assets and liabilities.

Categories of consequences mirror the categories of triggers. They may be:

- social ("all my friends smoke up"), situational ("it's great to drop acid before going to the movies"),
- cognitive ("I'm always going to be stuck in this dead-end job"),
- physiological ("a hit of cocaine will pep me up"),
- emotional ("a few drinks will calm me down").

COUNSELLOR'S TIP
Questions to ask about reinforcing consequences:

- What happens that you like, as a result of use?
- What gets better? What gets worse?
- What do you get rid of that you don't like?
- What (or how) do you do/think/feel differently?

Client Activities on the ABC . . . .

NOTE: You will find a group of client activities designed to elicit **ABC** information and self-analysis on pages 5-90 to 5-96 of the Appendix.

Before continuing with this Unit, we would like you to do ACTIVITIES 5.5, 5.6 and 5.7 on pages 5-32, 5-33 and 5-34.

ACTIVITY 5.4

For the characters in the videotaped case studies, list at least three triggers to their drug use, referring to each of the major life categories: social, situational, physiological, emotional and cognitive.

CINDY:

DANNY:

THERESA:

CHRIS:

ACTIVITY 5.5

From your own practice or work situation, describe **three** case examples for which you could do an **ABC** analysis of a particular problematic behaviour of a client (drug or other).

How could the analysis assist you in your work with these clients?

ACTIVITY 5.6

1. Pick a habit that you have always meant to change (such as eating too many desserts, smoking, biting nails).

2. What are its antecedents (triggers)?

3. What are the consequences of this habit that make you want to change? (Negative consequences).

4. What are the consequences of this habit that make it hard for you to give it up? (Positive consequences).

5. Which is easier for you to identify, the positive or the negative consequences?

6. For each antecedent and consequence, identify an intervention goal that will either:
   - eliminate or reduce the occurence of the trigger;
   - achieve the desired pay-off in another way.

ACTIVITY 5.7

1. Starting from an **ABC** analysis of any behaviour you have tried to change, or that of a hypothetical client, identify the three most relevant treatment goals to work on.

2. For each goal, establish whether or not it relates to an antecedent or positive consequence.

3. For goals geared towards antecedents, identify whether the goal is geared toward developing alternative responses or avoidance (or both), and explain.

4. For goals geared towards positive consequences, describe how developing a specific alternative behaviour will result in that positive consequence. Will the consequence be exactly the same? If not, how will it be different, and will this be acceptable?

5. Break each goal area down into its component steps or objectives.

Section 3: INTERVENTIONS TO CONTROL DRUG USE

In this Section, we will present strategies and techniques that you can use with young drug users, to assist them in achieving their drug use goals.

A client's first realistic drug use goal is usually to gain **control** over the use of one or more substances. Many adolescent clients describe themselves as being "out of control" in drug use triggering situations. They are sucked into powerful patterns of feeling and behaviour that end in drug use, and they feel helpless to challenge or change them. Other clients do have **some** control, and can choose whether or not to use, at least in some circumstances. In order to achieve their drug use goals, all clients need to **learn how** to refrain from using drugs in situations when they would normally use. This requires concrete plans for enhanced self-control, which you can help them develop. You should direct your efforts to both the antecedents and the consequences of the individual's use, which you have already identified with the **ABC** analysis.

The self-control strategies we present here are:

- self-monitoring,
- developing strategies to avoid drug use in high risk situations,
- developing strategies to cope with cravings,
- refusal training,
- relapse prevention and management.

NOTE: If a client is not ready for some or all of these interventions, or loses commitment to them along the way, then return to the exploration of drug use consequences and use motivational counselling techniques to move toward the active intervention stage again.

3.1 Self-monitoring

Self-monitoring is a general tool for increasing client awareness of, and control over, drug use. It requires him/her to keep a record or diary of drug use episodes and behaviours. If you use this technique, ask the client to keep records daily, and bring them to counselling sessions for discussion. A sample record form appears on page 5-99 in the Client Activities Appendix. Self-monitoring can focus on **drug use, drug cravings** or **drug refusals** (or all three):

Theresa is a good candidate for the use of self-monitoring, as she has not identified the role of alcohol in her life.

- **A drug use** is any occasion when a drug or alcohol is consumed/administered. Your client should note the type of drug, quantity and method of administration, as well as the day and time that the use occurred, and the situation or context.
- **Drug cravings** are intense feelings of desire to use drugs without actually using.
- **Drug refusals** are opportunities to use drugs that are turned down by the young drug user. They may involve "saying no" to others, or to oneself.

By keeping a record of drug uses, cravings and refusals over time, you and your client will have a graphic account of progress and regress. As counsellor, your role is to reinforce successful attempts at controlling drug use, and analyze failures in order to develop better coping strategies for the future. A written record can also alert you to substance substitution (the tendency to increase the use of one substance as another is decreased).

Self-monitoring can be used to identify triggers to drug use.

Another important function of self-monitoring is to help the client identify situations in which drug use and drug cravings are **triggered**, and pay-offs obtained. By recording the circumstances of these events, s/he can become more aware of thoughts, feelings, people, places, and activities that lead to drug use, cravings and refusals. Together, you then work out strategies for behaving differently in these circumstances, or avoiding them altogether in the future. The young drug user can then monitor the effectiveness of the strategies, as per the form on page 5-100 in the Client Activities Appendix.

For many clients, the very act of monitoring is an effective way of reducing or stopping drug use. The knowledge that s/he will be writing down and discussing the details of each use, each craving and each refusal can sometimes be reason enough to stop.

COUNSELLOR'S TIP

Some clients may not take readily to self-monitoring. It is too much trouble, or they are too disorganized to take the time, or they are not competent or comfortable as writers. With clients who are capable but reluctant, you should stress the importance of this exercise, and explore times and strategies to do the recording. If ability is a problem, monitoring can be simplified to suit the client's lifestyle and literacy level. Clients who will not self-monitor between sessions can be asked to make a record just before meeting with you, or to deliver a report orally. Some clients may be more comfortable using a tape recorder.

Before continuing with this Unit, we would like you to do ACTIVITY 5.8 on page 5-44.

3.2 Developing Strategies to Avoid Drug Use

The process of developing strategies to avoid drug use involves the following steps for you and your client to do together:

- analyze potential trigger situations,
- develop possible drug use avoidance strategies,
- rehearse the strategies,
- implement the strategies in real life situations,
- evaluate the outcomes,
- repeat the steps as necessary.

Once you and your client have identified high risk (Antecedent) situations, you should pinpoint precise triggers: "School" does not give you enough information to work with. You need to work on the "how-when-who-where-why" of the client's experience at school.

There are several ways to prompt the development of avoidance strategies. One is to ask the client to talk about typical situations in which drug uses have occurred, and imagine actions which s/he could have taken to avoid drug use. Another is to ask the youth about actions that s/he has used in the past to avoid drug use. Most clients have more strengths than they know, and should be encouraged to recognize and build on them.

See "problem solving", in Section 4.1 of this Unit.

Typically, drug avoidance strategies take one of the following forms:

- a plan for avoiding or eliminating the trigger situation altogether;
- a plan for getting out of the situation, should it occur;
- a plan for a non-drug-using response to the situation.

You can give your client a valuable head start toward implementing strategies by rehearsing them together in counselling sessions. This could mean talking through what s/he will do and anticipating any difficulties; or it could mean role-playing the strategy.

Rehearsal is especially valuable for teens, as they are very much rooted in their experience.

Usually, a client will be working on several strategies at once in order to deal with the various trigger situations that are facing him/her. Self-monitoring can help identify those that are most successful and those that require further work, as per the "Strategies" form on page 5-100. In the beginning, you will probably take an active role in helping the adolescent develop worthwhile strategies, but as treatment progresses the client should become more independent in developing and implementing his/her own.

Notice that we talk about "strategies" and "plans"; good intentions, promises and will power are seldom enough on their own.

3.3 Developing Strategies to Cope with Cravings

The urgent craving for drugs, which most clients experience during treatment to a greater or lesser extent, presents a particular high risk situation. Withdrawal from drug use is likely to produce particularly strong cravings. Many users are at a loss to know how to endure them, and will need special help in this regard. It is important that each client comes to understand that s/he **can** control his/her cravings, and that s/he learns how to do this.

COUNSELLOR'S TIP

You can reassure clients that cravings will decrease in frequency and intensity over time, and as the client develops alternatives to drug use. The basic idea is to normalize them. Your message should be: no, you won't die, no, you don't "have to", and yes, you can do something about it.

The process for controlling cravings is just like that for controlling use:

- learning to recognize cravings for what they are;
- identifying trigger situations;
- planning strategies to avoid them;
- planning strategies to cope with them;
- implementing strategies;
- evaluating outcomes;
- repeating this cycle as necessary.

Self-monitoring is, again, a useful way for a client to gain awareness of cravings, and move toward control. There are two basic strategies for coping with cravings:

- decrease the **frequency of cravings** by eliminating triggers;
- decrease the **impact of cravings** by engaging in alternative activities that stop them or make it easier to endure them. This strategy usually takes the form of a "diversion", which can either be **cognitive** or **active**: i.e. rechannelling thoughts or rechannelling energy.

Relaxation techniques may be useful — see Section 4.6 of this Unit.

You should encourage your clients to be inventive in all their attempts to control aspects of drug use, and to experiment until they find techniques that work for them.

3.4 Drug Refusal Training

"Saying no" to drug offers is not a simple skill, but it is an important aspect of gaining control over drug use. For the client, it involves learning how to refuse something s/he has decided not to do, in a manner that doesn't offend other people. It's an important step toward taking full control of his/her own life. The client's goal is to **know his or her own mind**, and then be pleasant but firm about not taking drugs when s/he doesn't want to — or for that matter, not doing anything else that s/he doesn't want to do. This can be difficult and stressful, especially at the time of life when peer influence is at its peak.

Clients describe the following as typical barriers to refusing drug offers:

- not wanting to offend a friend or acquaintance;
- worry about what others will think if I refuse;
- concerns about rejection by the peer group;
- anticipation of a hassle;
- not knowing what to say.

As counsellor, it is necessary for you to acknowledge and discuss the negative feelings the client will probably have about saying no, especially to friends:

- expectations of failure, inadequacy;
- fear of losing friends, being lonely;
- fear of ridicule.

Some component sub-skills that you can introduce to your client, and have him/her rehearse, are:

- sticking to your guns;
- sounding and looking determined;
- looking people in the eye when you say no;
- anticipating reactions of friends and others, and preparing your response;
- coping with teasing and rejection;
- knowing when to leave a situation of too much pressure or conflict.

Role playing a pressure and refusal scenario can be very effective.

COUNSELLOR'S TIP

The social skills involved in "just saying no" are very complex, and not easily transferred into real life. We will present more ideas on this subject in the next Section of this Unit. One comprehensive social skills teaching package that you might find useful as a resource was developed by Arnold Goldstein of Syracuse University and his colleagues, and described in Goldstein et al., *Skillstreaming the Adolescent*, 1980: Research Press, Champaign, Illinois.

3.5 Relapse Prevention and Management

A high rate of relapse during and after treatment is a fact of working with young drug users. For this reason, we take the view that relapse prevention and management must become a focus for treatment as soon as the client's earliest drug use goals have been achieved. In fact, because it is so common for clients to relapse before achieving sustained abstinence, we present relapse management as an essential part of the struggle to achieve control over drug use — rather than its more common presentation as part of aftercare.

A relapse is either:

- a single incident of serious (or prolonged) loss of control over drug use, or
- a general return to the client's previous pattern of substance abuse.

A counsellor's reaction to an episide of relapse can make it or break it.

For single (minor) occasions of drug use, with a return to abstinence soon afterward, some practitioners find it useful to employ the term "lapse" or "slip". The language you choose may communicate a message, a judgement or a prediction. "Relapse" sounds serious, possibly irrevocable. "Slip" sounds insignificant, perhaps of no importance at all. The client is likely to feel less guilty and discouraged in the case of a "slip" than a fully fledged relapse. In fact, a relapse is not a tragedy, and should be thought of as an opportunity for deeper understanding and another chance to succeed.

Frequency and Rate of Relapse

The frequency and rate of relapse after drug treatment has been an important question for addictions research. Typically, this research has shown that:

- regardless of the substance of abuse, incidents of relapse begin almost immediately after treatment ends;
- approximately two-thirds of all those treated will have had at least one relapse by three months post-discharge.

However, studies with a longitudinal perspective (e.g. 2-4 years) suggest that instability of outcome is the norm: clients who relapse during one follow-up period may be abstinent in the next, then relapse and recover again, indefinitely, or until they reach full abstinence. From this perspective, relapse is not necessarily an indication of "failure". It simply means that successful abstainers often make a number of unsuccessful attempts first.

The pattern may be somewhat different for adolescents. Some early stage users appear to "grow out of" their drug habits. Other young drug users appear compelled to test whatever control they achieve, by using drugs at the first available opportunity. Whatever the dynamics, risk of relapse remains high with adolescent users, and all practitioners must be prepared to address relapse issues in treatment as well as in aftercare.

Relapse Management

The frequency and intensity of relapse can usually be reduced if clients have some preparation during treatment. They also need to learn how to prevent a slip from becoming a full-blown relapse.

Relapse management entails:

- activities directed at **preventing** relapse;
- activities directed at **coping constructively** with episodes of relapse.

Clients often experience a "honeymoon" effect of high confidence and optimism at the end of a period of treatment or counselling relationship. They may feel prematurely "cured". However:

- the urge to use drugs may be stronger than the client has anticipated;
- the urge to use may arise in unexpected circumstances;
- skills learned in a protected environment (your office) are difficult to transfer to situations in the client's daily life;
- intensive treatment may have isolated them from "real life", with its pattern of stresses, pressures, and triggers to drug use.

With over-confident clients, it may be helpful to discuss typical relapse rates to help them face the very real possibility that "it can happen to you".

It can be a tricky therapeutic task to talk about relapse in a way that does not suggest that you **expect** or are giving permission for relapse. Make it clear that your prime goal is to prepare the client **to avoid relapse**, and secondarily to minimize the negative effects of a relapse should one occur.

The following client-centred activities are directed at preventing relapse. You will notice a familiar pattern of identifying risk situations, developing strategies, rehearsing and re-evaluating them:

- Use the **ABC** analysis, Inventory of Drug-Taking Situations (see p. 4-61) and self-monitoring techniques to identify high risk situations for relapse.
- Work out strategies to deal with identified triggers so that they do not lead to relapse.
- Rehearse the strategies so that the client is prepared for implementation should the trigger arise.
- Evaluate effectiveness of relapse prevention strategies. (You may want to make use of the Drug Taking Confidence Questionnaire [DTCQ-50]. This questionnaire assesses the client's confidence about coping with each of the high risk situations identified on the Inventory of Drug Taking Situations. Those areas showing little or no growth in confidence require further work in treatment.)

You will find this instrument listed in the Bibliography of this Unit, under the authorship of H.M. Annis.

It is equally important to help your young clients prepare to cope with episodes of relapse, and not to exaggerate their significance. Clients (and practitioners) sometimes interpret relapse as failure. Either (or both) of you may lose hope or feel incompetent. In fact, relapse should be framed as an opportunity for learning and new insight. Encourage your client to remain hopeful and optimistic, accepting the fact that fundamental change doesn't happen quickly or smoothly. Like the client, the professional must learn to keep relapse in perspective, resisting the urge to give up completely or to negate whatever real gains have been made. A relapse simply indicates:

- some backward movement;
- the need to refine plans for prevention.

Case example:

Carlo has successfully avoided his drug using friends by staying away from the mall. He is proud of having been abstinent from cannabis for 6 weeks. When he runs into a few of them by accident, he is caught off guard, and in confusion accepts a joint when it is passed. The "lesson" is not that Carlo is "hopeless", but that he needs to add refusal skills to his strategies for controlling drug use.

The client-centred activities listed in the Appendix are directed at preparing a client to cope constructively with episodes of relapse. They entail:

- practical and concrete plans to end the relapse;
- cognitive strategies to deal with negative thinking about relapse that may prevent constructive action.

- Assist the client to make a concrete, step-by-step plan of action to end a relapse. The objective is to make any relapse as brief as possible and to minimize the amount of drug or alcohol used.
- Problem solve and rehearse the plan so that it is ready for implementation if/when relapse occurs.
- Discuss past episodes of relapse — what triggered them and how did they end? Explore ways to avoid a repeat occurrence, as in the client activity on page 5-97.
- Identify thoughts and feelings that may arise during a relapse which could be barriers to constructive action. Feelings such as guilt and discouragement, and thoughts such as "now that I'm in relapse I may as well go all the way" should be countered.
- Assist the client in cognitive restructuring (see Section 5.2 of this Unit) — i.e. for each negative thought, help him/her to identify alternative thoughts that promote constructive action.

Before continuing with this Unit, we would like you to do ACTIVITY 5.9 on pages 5-45 and 5-46.

ACTIVITY 5.8

1. Exploring the technique of self-monitoring:
    - Self-monitor a behaviour you would like to change: i.e. overeating, arguing with a family member, etc.
    - Generate a list of situations which are high-risk for this behaviour.
    - For each situation, list strategies you think will help you avoid this behaviour.
    - Monitor and evaluate your use of the strategies this week.

2. Applying the technique of self-monitoring:
    - Explain self-monitoring to a colleague or family member. (This can be a role play or a real situation.)
    - Contract with him/her to self-monitor a behaviour you feel s/he needs to change (s/he may or may not agree).
    - Work with him/her to problem-solve barriers to action.
    - Help him/her develop strategies to facilitate the change — what steps would you go through to do this?

ACTIVITY 5.9

1. Recall a time you felt deeply disappointed in yourself, a friend, or a family member. Describe your feelings. How did you deal with them? Will you have the same feelings about a client who relapses? Will you deal with them in the same way?

2. Describe your probable reactions to the following four situations, addressing these issues as you do so:

- the importance of being able to identify and confront one's own feelings;
- the expectation that one will sometimes feel disappointed or angry, etc.;
- the recognition that these feelings need not hinder the therapeutic enterprise, and that on some occasions they may have a positive impact;
- the recognition that clients are not family or friends and that ways of intervening with clients will differ from the ways we react to family and friends;
- ways of channelling negative feelings into constructive interventions;
- building empathy;
- confronting commitment;
- teaching tolerance for uncomfortable feelings and perseverance in spite of those feelings.

- A client has a few drinks/uses a couple of times, is able to stop, calls you and requests an appointment as soon as possible.

continued →

ACTIVITY 5.9 (continued)

- A client has a full-blown relapse, is picked up by the police, and later arrives at your office dejected and defeated.

- A client has been using regularly since the end of treatment, steadfastly denies it, then you get a call from his/her parents saying client has been thrown out of house because of use.

- A client you like very much has numerous relapses over several months and it seems as though s/he will never get his/her life together in spite of your collective efforts.

Section 4: ALTERNATIVES TO DRUG USE

Adolescents who are involved with drugs are almost always suffering from life skills deficits as well. In this Section, we will discuss eight major areas of life functioning that may have to be addressed in order for the young people you work with to grow and mature successfully, without drugs. Our discussions contain many practical ideas for skills development with adolescents, but we are unable to present exhaustive training in all of these areas.

Note: Although you may develop your own intervention program covering all areas of potential deficit, many practitioners will choose to involve specialists, e.g. vocational counsellors, relaxation therapists, assertion trainers, family services, etc. It is not necessary for you to be able to intervene in all areas, but rather to be aware of your own skills and limitations, and to know where and how to find assistance when you need it.

If you need to refer a client outside your place of work for specialized skill development, you should:

- negotiate agreement with the young person regarding referral for work on a specific area;
- check with the referral agency to ensure that its staff can provide the required services;
- provide the specialist with a clear statement of the problem and needs of the client.

Before continuing with this Unit, we would like you to do ACTIVITY 5.10 on page 5-65.

4.1 Problem Solving

Most adolescent substance users have poor problem solving and decision making skills. They are easily overwhelmed when faced with a concrete problem, such as lack of accommodation, or one that is more abstract, such as "boredom" (e.g. lack of motification to get involved in a leisure activity).

Problem solving is both a basic human skill and also a crucial prerequisite for carrying out many of the activities of treatment (e.g. strategizing to avoid trigger situations). It is important, therefore, to assess a youth's problem solving ability early on, to establish its functional link with drug use, and to engage in skill development throughout the intervention period.

Problem solving is a core skill in any drug treatment program.

Problem Solving and Drug Use

Which two of the four teens in the videotapes do you think use drugs to compensate for problem-solving deficits?

An adolescent's natural ability to solve problems is usually (but not always) impaired when under the influence of drugs. However, many young users believe the opposite: that their drug use helps them when they are facing a problem. In their **ABC** analysis, clients often describe positive functional connections between drug use and problem solving — for example:

- Drug use enables the youth to concentrate better, or to be more analytical.
- Drug use enables the youth to abdicate responsibility for poor decisions of the past, or for failing to solve a problem: "I was high, so I just couldn't walk away from that fight at school."
- Drug use enables the youth to forget about a nagging problem, thereby relieving the stress that accompanies it. (This is, of course, only a temporary respite, since the problem has not been solved.)

If clients with these perceptions are to give up their drug use in problem situations, you will have to help them work out alternative ways to deal with their problems. Clients first need to see the relationship between their drug use and problem solving. This can best be conveyed through the **ABC** analysis, which was described in Section 2 of this Unit.

Few clients are deficient in all aspects of the problem solving process. It is important to identify skills as well as deficits. In the Client Activities Appendix, you will find a check list to guide the young drug user in identifying strengths and weaknesses.

Intervention: Problem Solving Steps

What follows is a step-by-step guide to improved problem solving. You and your client can go through the process together, or it may be given as a "homework" assignment.

Step 1: Identify a problem area: e.g. laziness.

Step 2: Describe the problem in detail: e.g. having no energy to do anything after school, including homework assignments.

Step 3: Generate strategies or potential solutions (at least six), through wide open brainstorming. Do not dismiss any idea that occurs to you just yet. To continue with the "laziness" example, a list might look like this:

- take a "wake up" shower or brisk walk (jog, etc.);
- drink coffee or tea;
- have a short nap;
- think of an enjoyable activity you really want to pursue;
- think of the positive consequences of the activity;
- ask someone you like to become involved with you in the activity;
- make a commitment to someone to do the activity together;

- do homework assignments with other people;
- arrange a work space that would make assignments easier to do.

Step 4: Eliminate the solutions which look inappropriate or unworkable, and narrow down the choices to three you are willing to try.

Step 5: Weigh the advantages and disadvantages of the chosen strategies, and choose the one with the fewest disadvantages or negative consequences.

Step 6: Try out the chosen strategy.

Step 7: Evaluate the results, and go back to step #5 if the chosen solution did not work. If nothing is working, go back to step #2 and analyze the problem more deeply, e.g. conflict at home may be interfering with your feelings and your motivation to do anything after school.

Before continuing with this Unit, we would like you to do ACTIVITY 5.11 and ACTIVITY 5.12 on pages 5-66 and 5-67.

4.2 Cognitive Skills[2]

Negative thinking and low self-esteem are a major trigger to teen drug use. They are also likely to be a barrier to positive change in other areas of a young drug user's life. Therefore, it is important for you to work with **all** clients to:

- examine their thinking patterns,
- identify those which trigger drug use or other maladaptive behaviours,
- work to develop more helpful thinking patterns which will facilitate or allow for behaviour change.

Flexible and positive thinking style is essential in drug treatment.

This process is called "positive self talk", or **cognitive restructuring**.

Cognitions and Drug Use

When doing their **ABC** analysis, most young drug users identify thought patterns that trigger drug use (e.g. "I'll never do well in school, so I might as well spend my time getting high"), but they do not understand their significance. You should explain:

- that thinking is "self talk" or inner speech;
- that what we say to ourselves affects how we feel and how we act;

2 This section is adapted from an unpublished Client's Manual for Cognitive Restructuring by Pam Santon (1987: ARF).

- that thoughts come and go so quickly, we often don't pay enough attention to them;
- that thoughts and feelings in the present may be the result of hurtful things that have happened in the past;
- that changing thought patterns really will help make a person feel better and change behaviour.

Furthermore, the youth should know that what a person says inside his/her head about self and drug use influences how successful s/he will be in controlling it. Cognitive distortion (unhelpful thoughts) often leads to a circle of excuses, drug use, guilt, and more drug use.

There are at least ten commonly held patterns of unhelpful thoughts:

- **all or nothing thinking:** thoughts which are extreme in their implications, or black/white in their categorization (e.g. "Everybody uses so I'll use"; "He does not like me so probably no one likes me").
- **over-generalization:** the hasty conclusion that because something happened once, it will always occur (e.g. "Since I haven't suffered in any serious way because of my substance use so far, I never will").
- **mental filter thinking:** preoccupation with one negative detail in a situation (e.g. "It doesn't matter that my grades are up this year, because I just flunked an easy test").
- **disqualifying the positive:** rejection of anything positive, including compliments and one's own efforts, which are seen as merely "good luck".
- **jumping to conclusions:** the tendency to presume or predict the future, or another person's thoughts and reactions, without cause or fact checking (e.g. "I know my father won't let me take the car tonight"; "I know Jane would never go out with me").
- **magnification and minimization:** exaggeration (usually of errors, fears and imperfections) or underestimation (usually of strengths, virtues and contributions).
- **emotional reasoning:** the presumption that feelings are equivalent to reality (e.g. "I feel bad, therefore, I must be a bad person").
- **should statements:** an attempt at self-motivation through guilt ("My parents have supported me all my life, I should stop letting them down").
- **labelling and mislabelling:** the tendency to measure oneself or others in very narrow and/or stereotypical terms ("I'm nothing but an addict").
- **personalization:** the assumption of responsibility or fault for an event when there is no basis for doing so ("My parents are always quarrelling because of me"; "My boyfriend is in a bad mood — it must be something I did").

Intervention

The first step in helping a youth change thinking patterns is to facilitate awareness of those automatic thoughts which are causing problems. Gaining awareness takes practice, and is best done through self-monitoring. Once the youth has developed the habit of catching his/her unhelpful thoughts and writing them down, s/he will be able to start questioning them.

You will find the model of a form for monitoring unhelpful thoughts which trigger or reinforce cravings in the Activities Appendix, p. 5-101. After a client has provided you with an example from his/her life, work with him/her to identify replacement thoughts, and in subsequent sessions discuss results. Repeat this sequence as often as necessary.

Once young drug users have identified unhelpful cognitions, they can begin learning and practising techniques to change the pattern:

- **Thought stopping:** Whenever an unhelpful thought occurs, the youth tells him/herself to STOP thinking that thought and substitute something more positive. You might suggest s/he visualize a stop sign and/or yell the word "Stop" internally (or even out loud), to assist in interrupting the thought. Another deterrent is to wear a thick rubber band on the wrist and snap it when an unhelpful thought comes to mind.
- **Worrying time:** The youth sets aside a limited time and single place to give full vent to negative thoughts. Instruct him/her to make note of any negative thoughts that occur during the day and to save them until the specified time and place.
- **Blow-up technique:** By exaggerating an unhelpful thought beyond belief, it can be made so ridiculous that it stops being hurtful.
- **Priming:** Priming is a technique to remind clients of the positive aspects of their lives. Instruct or help the youth to make a list of positives, and put them each onto a "priming" card. S/he should keep the cards handy, to be read and reread throughout the day.
- **Using cues:** Instruct the youth to use a routine part of everyday life as a signal to generate a positive thought about him/herself (e.g. stopping at a street light, or when eating lunch).
- **Noticing your accomplishments:** Instruct your client to write down the accomplishments of the day as they occur. Even things which seem trivial should be noted (e.g. got up on time, picked a nice place for lunch, etc.).
- **Positive self-rewarding thoughts:** Encourage the youth to pat him/herself on the back by saying rewarding things to him/herself. Adolescents often feel such inner speech is boastful, and may require further restructuring to overcome this attitude.
- **Time projection:** With this technique, the client acknowledges existing discomfort but breaks its hold by mentally travelling forward to a time when the discomfort no longer exists. Encourage him/her to accept some negative feelings as normal, not fatal or unending.

A client activity on helpful thinking appears in the Appendix, p. 5-102.

Before continuing with this Unit, we would like you to do ACTIVITY 5.13 on page 5-68.

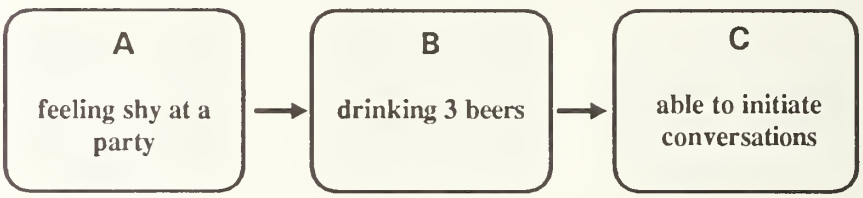
4.3 Social Skills

Many adolescent substance users are not adept at managing social interaction. They may use drugs to help them function in, or avoid, social situations. In some cases, their social skill deficits may have existed before their drug use, in which case they may be using drugs to compensate for their inadequacies. In other cases, the drug lifestyle interferes with the normal development of social skills, and may lead to a vicious circle of increasing feelings of inadequacy and increasing use.

Social Skills and Drug Use

When doing the **ABC** analysis of their drug use, many young drug users realize that their use serves a social function.

Example:



Normal social skills development may be impeded by drug use in any or all of the following ways:

As you read through this list, ask yourself which social skills were lacking in Cindy, Danny, Theresa, and Chris.

- **Initiating peer relations:** For many young drug users, peer relationships are organized around drug use. It is very difficult for adolescents to break with existing friends, no matter how negative their influence, and they are unlikely to do so unless they develop the necessary skills to make new (straight) ones.
- **Conversation skills:** The ability to carry on a conversation with peers and adults who are straight is often underdeveloped in young drug users. They may be very good at drug talk (e.g. accounts of drug experiences, quality of drugs, where to buy, etc.), but uncomfortable with other topics. They may use drugs in order to be more talkative. They feel more outgoing when they are high, and become more able to express themselves.
- **Listening skills:** Gaining the ability to hear and reflect on what others say to them is cited by some adolescents as a major function of their drug use. Conversely, others use drugs so that they can block out what is being said around them, or tolerate it better.
- **Presenting oneself well:** In order to be accepted by non-drug-using peers, many adolescent drug users need to abandon a presentation style which readily identifies them as a drug user, i.e. in terms of dress, grooming, non-verbal behaviours. Other young people, whose self-presentation has resulted in prior rejection from peers, may feel more comfortable with their inadequacies when they are high, or may have found welcome acceptance from other drug users.
- **Control of aggressive behaviour:** Aggressive behaviour, such as threats and put-downs of others, is an inappropriate way of expressing negative

feelings. However, within drug subcultures, it is quite acceptable. Some youth use drugs to enable them to be more bold in their expression of threats and put-downs, while others who are too aggressive may use drugs to temper these tendencies.

- **Refusal:** Nearly all youth will need to develop an ability to refuse offers to buy or share drugs, to refuse to go to places where drugs are used, and so on. For many, the acceptance of a drug offer has become so automatic that they will need to work hard to develop alternative responses to these situations. (See Section 3.3 on refusal skills.)

  The feeling of "pressure" to accept drug offers may be a projection of the youth's own desire to use or his/her fears of rejection. Or it may reflect a reality in which peers are persistent in their offers and make refusal a difficult or unpleasant experience.

- **Expressing positive content:** A very common trigger to drug use is the youth's desire to express positive feelings, such as:

  - to reward him/herself;
  - to celebrate an event;
  - to have a good time.

  In such cases, drug use functions to intensify positive feelings.

  Drug use can also generate positive feelings to replace bad ones, e.g. to bring an adolescent out of a "down" mood. Clients who have difficulty expressing their positive feelings may feel that they are friendlier when they are on drugs, or that they are better able to express their love or affection to others when they are high.

- **Expressing negative content:** Young drug users are likely to have difficulty coping with or expressing their negative feelings, such as anger, sadness, frustration, fear. For some, drug use is the only way to relieve the stress that such feelings create. For others, drug use enables them to express negative feelings that they have suppressed.

- **Conflict resolution:** By the nature of his/her developmental phase, the life of a typical adolescent is characterized by periods of tension in relation to social norms. The young drug user may be in further conflict with the school system, the family, the law, or other authority figures. Drug use can offer an escape from a life fraught with conflict, or may enable the youth to confront the conflict head on, though often inappropriately.

- **Standing up for yourself:** Adolescents may lack the assertiveness skills necessary to stand up for themselves, or express themselves as they would like to. Drug use may enable the under-assertive adolescent to feel and act more confident. Conversely, over-assertive individuals may use drugs to temper aggressiveness.

  Under-assertive teens tend to have low self-esteem because of their lack of success in dealing with interpersonal situations and resolving conflict. Drug use may erase the negative feelings that result from their failures. The following client activity is something you might use to help clients set assertiveness goals.

Intervention

In brief, the steps below can be followed in social skill development:

1) **Specify the social skill area(s) that require change**, and explore how change would have a positive outcome on social relationships and substance use.

2) **Break down each skill into its component behaviours** for the youth to practise.

   Examples:

   - initiating conversation: introducing oneself; introducing topics;
   - maintaining conversation: self-disclosure; paying attention;
   - listening skills:
     - improve eye contact;
     - pay more attention to non-verbal cues;
     - interrupt less often.

3) **Prioritize the specific target behaviours** so that systematic training can begin, starting with the easiest first and progressing to the most difficult behaviour.

4) **Rehearse the target behaviours** in a role playing exercise. Audio or video feedback can be used to assist the youth in practising the behaviours.

5) **Apply the skills** in real life situations, and discuss progress.

6) **Identify any "negative self talk" or other barriers** to change, for cognitive restructuring and problem solving.

COUNSELLOR'S TIP

The **Social Skill Training Selection Form** is a 16-page, self-administered social skills assessment package for adolescents. Clients are directed to choose three skills areas they would like to work on after reading a manual which describes ten areas of possible development. The package is available from Mr. Garth Martin, Addiction Research Foundation, Toronto, Ontario, M5S 2S1.

Before continuing with this Unit, we would like you to do ACTIVITY 5.14 on page 5-69.

4.4 Leisure

Leisure activities are pursuits which people engage in for their intrinsic value and pleasure. For teens and adults both, a well-balanced leisure life includes activities which are both active and passive, and which are performed:

- alone and with others,
- at home and in the community,
- indoors and outdoors.

In working with young substance users, you can promote leisure activities as alternatives to drug-taking behaviour, as a means of social re-integration, and as a relapse prevention strategy.

You will want to find out:

- how your client currently spends his/her leisure time,
- the kinds of leisure activities that s/he values and engages in,
- the former leisure activities s/he has given up since becoming involved with drugs,
- whether current leisure pursuits are paired with, or related to, drug use.

Leisure and Drug Use

The relationship between leisure and drug-taking behaviours is complex, and must be investigated in order for you to assist the individual to formulate positive leisure goals. For many young drug users, substance use is an integral component of leisure — or even the central leisure activity:

- Some have not developed a repertoire of drug-free leisure activities, nor do they value them. This group often identifies "boredom" as a major trigger to their drug use.
- Others have dropped out of former activities because they could not be carried out while "high".
- For others, drug use facilitates participation in other activities. This is particularly true for those leisure activities which require social skills and interactions in which the individual perceives him/herself as incompetent. For example, after smoking a joint, a youth may feel more inclined to invite a new friend to shoot a game of pool.
- Other young users, who do have an active leisure life, may use drugs because they believe substance use enhances enjoyment or performance. Thus involvement in the leisure activity reinforces and triggers drug use. Some typical examples are: enjoying music more while high; feeling more creative when writing, painting or composing music if high; feeling more competitive and taking more risks in sports while high.

Participation in leisure activities is an excellent way for youth who are immersed in the drug subculture to get back in touch with "straight society". As well, leisure pursuits can help to enhance self-esteem, provide opportunities for developing social skills and alleviate boredom. Leisure activities can also

function as drug-free methods for coping with life stressors resulting from conflict with family, authority, etc.

Identifying Leisure Problems

Assessment of the client's leisure participation and drug-use behaviours can be done in three ways. The first is the **ABC** analysis conducted with the client. This analysis will reveal the relationship between drug use and leisure activity, now and in the past. The second method is a systematic review of the youth's leisure history using an interview format. Things to look for are:

- leisure values and expectations,
- past trends of leisure involvement especially prior to drug use,
- complaints of boredom,
- the extent and adequacy of social networks,
- range of leisure activities,
- knowledge of community resources,
- financial resources,
- balance between active/passive, social/solitary, and spontaneous/planned activities,
- satisfaction and enjoyment derived from leisure pursuits,
- unrealistic expectation of plans.

The third method is to ask the client to complete an activity inventory, identifying activities s/he engaged in prior to substance use and during periods of substance use, and those that s/he wishes to pursue in the future. Some common patterns that emerge are:

- interests have remained, but they have changed from active to passive, e.g. from playing football to becoming an "armchair quarterback";
- overall participation levels have diminished;
- activities nominated for the future are dramatically new to the client, and may not be realistic for him/her to pursue.

The data you gather will assist you and the young drug user to develop achievable and relevant leisure goals.

Intervention

The following steps can be taken to facilitate change in an adolescent's leisure life:

- identify time allotted to leisure pursuits in comparison to other life roles the youth must fulfil. You might use a pie chart to dramatize the pattern of a client's activities over a 24-hours period.
- identify leisure needs and expectations, and identify activities which fulfil them.

- identify leisure interests which produce the same positive consequences the client now obtains from drug use.
- identify cognitive and other barriers (e.g. lack of funds) to participating in substance-free leisure activities, then implement cognitive restructuring strategies and problem solving as necessary.
- review leisure resources available in the community, using a written handout.
- plan participation in one or more specific leisure activities, including all steps to facilitate follow-through.
- review the client's social network to ensure that "straight" friends exist with whom the client can attend activities.
- develop a weekly schedule that incorporates realistic leisure plans, including activities planned for times that are high-risk for cravings or drug use.
- role play high-risk social situations to develop a sense of competency.
- monitor and re-evaluate experience.

How did Pat Gardiner use leisure skill development with Danny? (videotape #4)

Before continuing with this Unit, we would like you to do ACTIVITY 5.15 on page 5-70.

4.5 Vocational Skills

For adolescents, "vocational skills" may refer to school, work or both. For many, drug use has an adverse effect on their performance at school or work, resulting in absenteeism, poor grades, suspension, expulsion, unemployment, poor work histories, etc. The objectives for you in focusing on the vocational area are:

- to eliminate drug use at school and at work;
- to improve basic school and work skills;
- to facilitate choice of a productive and satisfying vocational path.

It may be useful to refer young drug users to an individual or agency specializing in this field.

Vocational Deficits and Drug Use

Many adolescents report using drugs either just prior to going to school or work, at school or work, or immediately after school or work. This should alert you to the possibility that there are significant triggers in that situation. Availability and the presence of drug-using peers may be factors, but more often than not drug use in these settings is **functional**. It may be used:

Despite appearances, drug use at school or work is functional for the user.

- to combat boredom;
- to deal with a learning deficit or performance anxiety;

- to suppress anger, conflict, criticism, etc.;
- to deal with failure or dissatisfaction;
- to gain social acceptance.

Some adolescents feel that they do their work better when they are on drugs. This is particularly common in the creative fields such as music, film and art. While they may perceive that they are performing better on drugs, objective observers usually disagree.

If you do an **ABC** analysis of drug use at school and work, you and your client will identify the triggers to drug use in these settings, and its functions (or pay-offs being delivered). A thorough assessment of the client's experience of school or work should cover such areas as attendance, satisfaction, study and work skills, work history, grades, relations with authority figures such as boss or teachers, reasons for leaving a job or dropping out of school, vocational aspirations achieved and not achieved, short-term and long-term vocational goals.

COUNSELLOR'S TIP

Don't forget that for some young drug users, dealing drugs is their sole or principal source of income, which is a significant barrier to their being able to stop using.

Intervention

The following steps can be taken to address the vocational area with young drug users:

- Identify triggers to drug use at school and work.
- Identify and implement alternative ways to get the pay-offs of drug use at school or work.
- Identify sources of conflict at school or work, and use problem-solving techniques to eliminate them.
- Increase the youth's knowledge and awareness of the expectations of employers and educators, and how to meet those expectations.
- Facilitate the youth's identification of his/her vocational interests, aptitudes, expectations and needs, and work out realistic plans for achieving them.
- Set realistic short- and long-term vocational goals, and develop a step-by-step plan to meet them.
- Develop budgeting skills so that financial factors do not prevent success in reaching goals or act as triggers to relapse.
- Utilize role play to rehearse all new skills learned.
- Monitor progress towards goals on an on-going basis.

COUNSELLOR'S TIPS

- Some aspects of vocational development may have to wait until drug use has been brought under control.
- Caution must be exercised so that over-optimistic aspirations do not lead to failure and drug relapse.

4.6 Stress Management and Relaxation Training

Stressors encountered by adolescents come from a wide variety of sources, e.g. their relationships with family, authorities, and peers; their failure to meet expectations at school, work or leisure; their own biological and emotional development; and, at times, their negative thinking patterns.

Although the effects of these stressors may be obvious to professionals working with youth, the idea that stress can be a trigger to drug use and a barrier to goal achievement is often very poorly understood or accepted by the youth themselves. They are more likely to deny the impact of stress than to develop good coping skills.

The objectives in focussing on stress management with young drug users are:

- to foster awareness of stress as a normal aspect of life;
- to provide the youth with effective relaxation skills;
- to teach stress reduction strategies;
- to substitute alternative behaviours, including relaxation and cognitive restructuring, for the stress-reducing effects of the drugs;
- to assist clients in experiencing both the physical and cognitive changes that they can make through their own efforts.

Drug Use and Stress

Many drugs have the immediate consequences of inducing a state of relaxation and well being. For many young people who have not developed alternative ways to cope with stress, drugs offer a quick and effective way of reducing it temporarily. When drug use is stopped, some young users experience stress and discomfort that was masked by the use, e.g. chronic pain or sleep disorders. Some treatment time should be devoted to dealing with these areas as part of the adjustment to a drug-free lifestyle.

Identifying Stress-Related Problems

A **Personal Tension Profile form** appears in the Client Activities Appendix, p. 5-104: you can use it to increase a client's awareness of his/her stressors and stress-related symptoms. Self-monitoring of stressful incidents can also point out

situations in which stress management techniques should be applied. A Tension Diary form is included in the Activities Appendix, page 5-105.

Intervention in this area has two components: stress management and relaxation therapy.

Intervention (1): Stress Management

If you are working with young drug users as individuals, you can apply problem-solving techniques to each stressor as it comes up. Encourage clients to identify "pressures" and "hassles" in their lives, and describe their responses. Some teens will say that "nothing bothers them". If clients have trouble recognizing that stress is part of their lives, point out the physical and emotional "flags", like anger and stomach ache. Recognition is the first step on the way to change.

Whether you are working with individuals or groups, you can lead discussion on the following topics, in sessions linked to relaxation practice:

- understanding the concept of stress (= adaptation to change);
- identifying general and personal stressors (use the Personal Tension Profile in the Activities Appendix);
- understanding the alarm response as a normal physiological response;
- monitoring stress and developing coping strategies (use the Tension Diary in the Activities Appendix);
- identifying the role of emotions in on-going stress, and appropriate ways to deal with feelings;
- understanding the role of correct posture, breathing control and physical activity in reducing stress;
- attaining natural sleep;
- using the techniques of cognitive restructuring as a means of reducing stress.

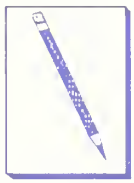
Intervention (2): Relaxation Therapy

The object is to teach young drug users how to reduce physical and emotional tension using a few simple bodily techniques. Relaxation is usually taught with clients in the lying position, so that the effects of gravity are reduced and the state of relaxation is more easily attained. It is also useful to have the clients do a few body stretches prior to doing the other techniques, to focus their attention and increase body awareness.

- The easiest exercise is the Progressive Muscular Technique, which incorporates the use of slow, controlled breathing and rhythmic, alternate contraction and relaxation of particular muscle groups to induce a state of generalized relaxation.
- Once some success has been achieved with this technique, other techniques can be introduced, using the sitting position. It is especially important that clients experience a relaxed state while in the sitting position, as it is the position in which they spend much of their waking time.

- Other techniques include the autogenic, guided imagery, and specialized breathing techniques. The latter two are especially useful in that they deliver an immediate impact, which is important in working with adolescents who have experienced the immediate gratification of drugs.

Before continuing with this Unit, we would like you to do ACTIVITY 5.16 on page 5-71.



4.7 Wellness Promotion

Wellness promotion is intended to facilitate the best possible functioning in all areas of life, including the traditional domains of physical and emotional health. It also contributes a non-traditional orientation: an orientation that stresses the client's strengths, rather than focusing exclusively on his/her weaknesses and health deficits, and tries to coach him/her toward optimal wellness at a comfortable pace.

Wellness may be the final goal of all drug intervention work with youth.

The counsellor's role is, insofar as possible, to substitute positive language and a celebration of the body for traditional "doom and gloom" warnings about the consequences of mismanaging one's health. If you can foster an attitude of awe and respect for the body in young drug users, they will become less and less willing to abuse it.

You can use the following to develop your own program of wellness promotion:

N.L. Tubesing & D.A. Tubesing (Eds.). (1984). *Structured Exercises in Wellness Promotion,* Volumes I and II. Whole Person Press, P.O.Box 3151, Duluth, MN 55803.

Although you may not be a specialist in the health field, you do need to be acquainted with some issues that are particularly relevant to the adolescent substance abuser. You need only provide basic counselling and information, referring out when your limits are exceeded.

These areas include:

- **Nutrition:** Substance use affects nutrition, both in terms of eating patterns and the body's ability to use food appropriately. It is important for you, or another professional, to:
    - explore the client's typical daily diet habits;
    - discuss the effects of substance use on nutrition and on the body;
    - instruct the client on the functions of nutrients and how to plan a balanced diet;

- facilitate the client's own planning and monitoring of a balanced nutritional intake.

- **Pain control:** Regular use of substances dulls normal pain responses, and clients are often surprised and upset by the return of normal pain when substance abuse is stopped. Awareness of this transitional experience, coupled with increased skill in controlling pain without substances, is an important prerequisite to giving up drugs for some youth. You (or a more expert colleague) should:
  - review how the body responds to pain;
  - instruct the client in non-invasive pain prevention or control strategies to deal with the pain they have identified in their ABC or during medical assessment;
  - teach self-monitoring of pain, control techniques, and outcome;
  - reassess the effectiveness and appropriateness of pain control strategies on an on-going basis.

  Because pain may indicate a medical problem, clients with persistent complaints about pain should be assessed by a qualified medical practitioner, and treatment plans shared.

- **Sexuality:** Adolescence is a time of exploration, experimentation, and forming a sexual identity. Coming to terms with sexuality and developing a mature attitude to sexual relationships is often inhibited by drug use. Your intervention should aim to:
  - facilitate open discussion about sexuality;
  - facilitate the exploration and clarification of a youth's personal value system as it relates to sexuality and interpersonal relationships;
  - explore how the youth's self-presentation (i.e. dress, body language, etc.) expresses his/her sexuality, and whether this message is congruent with his/her value system.

- **Birth control and sexually transmitted diseases:** Substance abuse often interferes with responsible sexual behaviour. The result may be an unwanted pregnancy or a sexually transmitted disease (STD). Adolescents may lack information and resources to facilitate responsible planning and action. You (or a colleague) should:
  - review male and female reproductive systems and processes;
  - inform the youth about various birth control options, their effectiveness, advantages and disadvantages;
  - instruct clients about the signs and symptoms, prevention, and treatment of sexually transmitted diseases;
  - inform clients about community resources available for information, counselling and treatment.

- **AIDS:** Substance users are a high-risk group for HIV infection. You should discuss risk behaviours such as unprotected intercourse and needle sharing with every young drug user, and provide information about safe sex and needle cleaning procedures.

Before continuing with this Unit, we would like you to do ACTIVITY 5.17 on page 5-72.

4.8 Family Relations

The adolescent's struggle for autonomy from family is normal and healthy. When alcohol and drug abuse is introduced into the struggle, it can become problematic and even destructive. Yet the resolution of the substance abuse, as well as the youth's eventual sense of well being as a young adult and beyond, can be significantly influenced by the strengths and deficits of family relations during this critical period of family development. It is incumbent on the counsellor to determine the kind and level of family work that may be required in a given situation. The need may range from parenting or family education services all the way to long-term family therapy.

For more on family dynamics as it relates to drug use, see Chapter 6 in your Book of Readings.

The table below suggests guidelines for determining the level of family involvement that is required with different young drug users.

FAMILY INVOLVEMENT		
TYPES OF FAMILY INVOLVEMENT	**LEVEL OF INTERVENTION**	**OBJECTIVE**
Family orientation	Orienting the family to the philosophy and approaches of the youth service.	To inform the family about the program that the youth is embarking on, and to enlist family supports.
Parenting/family education group	Involving parents and/or families in family life education with special reference to substance use issues.	To inform parents and/or families about family relations issues and how they may be relevant to substance abuse.
Family counselling	Contracting with the family for interventions aimed at resolving identified problems.	To bring about resolution of problematic issues identified by family members and related to the youth's drug use.
Family therapy	Contracting with the family for intervention aimed at chronic and systemic family dysfunction.	To bring about change to elusive and intractable areas of systemic family dysfunction identified as directly related to the youth's substance use.

COUNSELLOR'S TIP

Sometimes parents are baffled and discouraged by their teenagers, and say that they "don't know how to talk to them". Here are some suggestions you might make:

- Make time for your teen. Try to do things together. If your suggestions and invitations are turned down, keeping asking.
- Listen — really listen. Put other things aside, and give your child your full attention until s/he decides that the conversation is over.
- Keep things in proportion. Don't treat the minor disagreements as more serious than they are.
- Tolerate differences. Grant your teenager the right to be a unique individual, as distinct from yourself as you are from your parents.
- Respect your teenager's privacy — but if behaviour is worrying you, speak up about it right away.
- Don't tell your teen that his or her feelings are a passing phase, that he or she will soon grow out of it. Teens live in the moment, and simply aren't able to project that far into the future.
- Don't judge. They are right to say that "you don't know everything". Try to stick to the facts when you criticize — and don't forget to give them praise as well.

ACTIVITY 5.10

1. List the areas of life functioning in which you are prepared to intervene:

- ☐ problem solving,
- ☐ cognitive skills development,
- ☐ social skills development,
- ☐ leisure skills development,
- ☐ vocational skills development,
- ☐ stress management,
- ☐ wellness,
- ☐ family relations.

2. For each item on your list, specify further knowledge and training you may require.

3. List the referral resources available in your community and the specific services they can provide.

4. What can you do to help your clients in life functioning areas where you feel that you lack skills and there are no resources to which to refer?

ACTIVITY 5.11

Follow the problem-solving steps on pages 5-48 and 5-49 to resolve a barrier that you have, or impediment you face, in relation to your work with young substance users.

Issues to be addressed when doing this activity:

- how difficult is it to be specific about the problem definition?
- what difficulties can be anticipated in implementing the steps?
- how can these be addressed with clients?

ACTIVITY 5.12

Adolescents have many dysfunctional ways of dealing with their problems. Think of three clients in your work context who perceive that they have insurmountable problems. Identify the unhelpful approaches they are using. Then ask a colleague to take the part of one of these clients, and role-play the problem-solving steps on pages 5-48 and 5-49. What is the impact on the "client"?

ACTIVITY 5.13

Do the following activities, addressing these issues:

- how entrenched were the negative thoughts?
- what were the main barriers to changing them?
- how effective were the cognitive restructuring techniques that you chose?

1. List negative thoughts you have had about working with adolescent substance users.

2. How have these thoughts affected your behaviour?

3. For each thought listed in #1, work out a more helpful (but realistic) replacement thought.

4. How do you think the replacement thoughts would change your behaviour?

5. Practise thinking in these new ways, e.g. by repeating key phrases to yourself in quiet moments, and evaluate the effects.

ACTIVITY 5.14

1. For each of the ten listed social skill areas (pages 5-52 and 5-53), give an example from your work context of a counter-productive response made by a young drug user. Then suggest a more productive alternative.

2. Suggest a function that drug use could be playing in each of the ten listed social skill areas.

3. What social skill function(s) is served by drug use for each of the central characters in the videotaped case studies: Cindy, Danny, Theresa and Chris?

ACTIVITY 5.15

Working with a group of adolescents (or individual client), lead them in a discussion of attractive and unusual leisure activities. They should have no trouble coming up with twenty of them. Then discuss the barriers to engaging in each, and apply problem-solving techniques to produce strategies for overcoming the barriers.

ACTIVITY 5.16

Identify and describe an adolescent in your work context who now uses drugs to deal with his/her stress. How could you apply stress management techniques in this case?

ACTIVITY 5.17

1. In which of the areas included under "Wellness" do you feel competent to intervene, and how?
   - ☐ nutrition
   - ☐ pain control
   - ☐ sexuality
   - ☐ birth control and STDs
   - ☐ AIDS.
2. For each topic, list resources in your community to which clients can be referred.

3. Discuss with a colleague or supervisor your feelings about addressing the issues of sexuality, birth control, and sexually transmitted diseases with a teenager.
   - What are your concerns?
   - How might your personal values affect your work in this area?
   - Do you think your value orientation will be valuable to the client?
   - How will you deal with a client whose cultural background means that his/her value system is very different from your own?

Section 5: AFTERCARE

In this Section, we will describe the crucial role of aftercare in maintaining and extending the work of active treatment.

Young drug users who go through a treatment program may find little in the way of on-going counselling or informed encouragement, once they leave that environment. The purpose of **aftercare programs** is to fill that gap.

The objectives of aftercare are **to ensure that young drug users continue to work on treatment goals and to maintain the goals that have been achieved,** after they have finished an intense period of counselling or other drug program. If possible, the aftercare program should be a direct extension of primary counselling, so you should consider providing it yourself. At the very least, the two services should be closely linked, and a transition mechanism established.

More and more schools are beginning to undertake the provision of aftercare.

Aftercare programs are built on the assumption that continuing support can:

- remove or reduce post-treatment factors associated with relapse,
- strengthen those post-treatment factors associated with successful maintenance of drug use goals.

During primary treatment in an intensive (residential) program, a youth may have developed a sense of pride in being drug-free based on the on-going reinforcement and support from those in treatment with him/her. A more positive sense of self may have emerged, providing him/her with inner motivation to remain drug-free. To his/her dismay, this support is often absent when s/he re-enters the community, and his/her achievements may begin to collapse.

Factors associated with relapse following drug counselling are:

- family conflict,
- family substance use,
- peer substance use,
- social isolation,
- absence of productive role (school or work),
- absence of satisfying leisure pursuits,
- stress: mental or physical pain,
- trauma.

Review the discussion of relapse in Section 3.4 of this Unit.

This research-based list suggests three main **goals for aftercare:**

Goals for aftercare

- to help a client develop or enhance social supports in the community, and eliminate patterns of interaction with family and peers which contribute to relapse;
- to help a client play a productive role in school, work or the home, and become involved in appropriate recreation and leisure activities;

- to develop and practise a repertoire of skills:
    - skills necessary to become involved in social, vocational and leisure activities in the community;
    - skills necessary to cope with stress and negative emotional states;
    - skills necessary to prevent and cope with relapse.

Each of these areas of skills development has been discussed in greater detail in previous sections, as aspects of active treatment. However, their full achievement generally takes a long time, so they continue to be the focus of client/professional efforts in aftercare.

The goals of aftercare can be pursued through individual, group, peer group, or family counselling. A particular client may need more than one of these interventions in his/her aftercare treatment plan.

Family issues are an overriding concern for most young people in aftercare. Issues such as parental trust and support, the fulfilment of mutual expectations, and the family's response to possible relapse may require your on-going attention. Frequently, a change in the family dynamics generated by the young drug user's pursuit of abstinence unleashes other underlying problems. Family treatment as part of aftercare can assist the client and his/her family in handling these repercussions.

You might consider setting up a support group for your clients, as peers can play a vital role in promoting a non-drug-using lifestyle.

It appears to be particularly beneficial for adolescents to be part of a post-treatment discussion or support group of peers. Group participation reduces feelings of isolation and can provide a supportive re-socialization experience, in which the youth can receive honest feedback when attempting new solutions and strategies to avoid using substances, and develop sympathetic, non-exploitive relationships with peers.

Among the possible goals of a **youth aftercare group** are:

- to provide support for staying drug-free;
- to provide support for personal aftercare goals;
- to promote drug-free friendships;
- to encourage the exchange of feedback on episodes of relapse;
- to provide a place to continue the feelings-oriented modes of expression and relating that can be so fulfilling during treatment and so lacking in everyday life.

These goals give most aftercare groups a very full agenda, often not allowing time to address deep personal, family, or emotional issues. Individual or family counselling may be needed to complement group work.

Some of the techniques that can be used by the group are:

- role playing the use of drug refusal skills,
- discussing on-going ways to deal with cravings,
- planning alternative social experiences and leisure activities.

Self-monitoring and re-evaluation of strategies for achieving drug use goals comprise the main thrust of aftercare. Ask your client to keep a record of cravings, drug refusals, and drug uses, paying particular attention to triggers (antecedents) and how well they are handled. As well, encourage him/her to monitor the successful use of new skills which may have been developed during treatment. Discuss spare-time planning and follow-through, and assist your client to problem-solve any barriers to goal attainment.

A fundamental task facing all aftercare programs is to convince young drug users that they need to participate. Some may drop out because of disillusionment or embarrassment if they are unable to maintain abstinence during this period. It then becomes your responsibility to encourage the client's continued effort, and re-establish realistic goals. Other clients may experience a "treatment high" or "honeymoon phase" during the first few post-treatment weeks. Especially with adolescents, their over-confidence may lead them to abandon aftercare at this stage, buoyed by the feeling that they are "cured" and do not require further treatment.

Some of Theresa's problems with alcohol might have been avoided if she had stayed in aftercare.

Some clients find that they are unable to attend aftercare because of school or work schedules, perhaps further compounded by distance. In these cases, a flexible staff schedule involving evening or lunch time appointments may accommodate them, or they may require referral to a more convenient agency.

Aftercare is basically an on-going evaluation of the young client's adaptation to reality. It also serves a significant purpose for the practitioner and the researcher: it allows us to evaluate the effectiveness of whatever treatment the client has experienced. It exposes the strengths and weaknesses of a particular treatment plan. A client's post-treatment problems may indicate that some aspects of treatment were not effective. Although this may be discouraging for the client and practitioner, it is also useful information for future planning.

COUNSELLOR'S TIP

For more information about an newly developed aftercare program situated in a school, contact the Marion M. Graham Aftercare Program, 602 Lenore Drive, Saskatoon, Saskatchewan, S7K 6A6, tel: (306) 242-7501.

Section 6: PROGRAM EVALUATION

Although program evaluation is not a specifically youth-and-drugs topic, we feel that it could be very useful in assisting you to improve your results with young drug users.

Most counsellors, whether working in single person practices or as employees of an agency, record information on the clients they see and the activities they carry out as counsellors. This information can be used to:

- provide feedback to the counsellor, or the agency, about the progress of clients during treatment and follow-up;
- motivate clients by reminding them of their progress;
- evaluate the effectiveness of the services provided by the counsellor or agency.

In simple terms, program evaluation involves objectively describing "who was served?", "what was done?", and "what were the results?" It focusses upon the processes of treatment and the outcome of the intervention.

Issues that might be addressed in evaluating **process** include the following:

- Is the program appropriate to the type of clients receiving the service and the types of problems those clients have?
- Is the agency serving the population for whom funding was intended and the services were designed?
- Are the projected numbers of clients receiving service?
- How effectively does the program make use of its resources?
- Are pre-set standards attained?
- Are staff responsibilities equitably distributed and undertaken?
- Are treatment methods and records completed in the approved manner?
- Do staff training and development opportunities meet professional standards?

Issues that might be addressed in evaluating **programs** are:

- What proportion of the clientele attained and maintained the various goals that were set for the program?
- Were the clients satisfied with the services that they received?
- What characteristics (of clients or interventions) were predictive of outcome from the program?

In summary, the objective of evaluation is to assess the quality of service that a program provides, and to assess what aspects of the program seem to work with what type of client. This can provide an objective basis for improving the service.

Before continuing with this Unit, we would like you to do ACTIVITY 5.18 on page 5-81.

6.1 Describing the Clients of the Program

Client records can be used to evaluate individual progress.

As was noted in the Unit on Assessment, it is essential to collect good baseline data on the clients and their problems and current levels of functioning. This provides a reference point against which changes in the clients' status can be evaluated. It is important to collect the information in a standardized fashion, so that the same procedure can be repeated at follow-up, regardless of who does the second interview. For example, answers to the question "are you currently abstinent?" would not be as useful as those to the question "have you been abstinent from alcohol for the past four weeks?" The latter would yield more reliable and comparable information. Such data should be collected using a structured interview form, or some other standardized measure of client problems and functioning.

There is often some question about the validity of substance users' self-reports, although studies have tended to show that they can be quite valid if the conditions for collecting the information are properly structured. Speaking generally, self-reports tend to be most accurate when:

- there are no perceived penalties for truthfulness (such as the disapproval of a therapist),
- the client has reason to trust the motives of the interviewer and is informed of the purpose of the questions,
- confidentiality is discussed,
- the client is not intoxicated when reporting,
- the client knows that attempts will be made to corroborate the report independently.

COUNSELLOR'S TIP

In collecting information about recent drug or alcohol use at follow-up, it is important to ensure validity of client self-report. Among the most useful methods is an interview with a collateral source of information, who can corroborate the client's information.

6.2 What Is Done: Describing the Content of the Program

A service must be objectively described if it is to be evaluated. There are various methods by which this can be accomplished.

At the level of the program, there should be an objective description of:

- the components of the program,
- the rationale for including those components,
- the staffing requirements,
- the educational and professional qualifications of staff involved,
- the methods used within each component,
- a description of the manner in which evaluation is to take place.

At the level of the individual client, there should be policies specifying the nature of information to be recorded on each client contact. For individual counselling sessions, information is usually collected concerning: attendance; the demeanour of the client; whether the goals set in the last session were achieved; what was the focus of the present session; what goals were established for the next appointment; and what homework assignments were set.

Where evaluation is a routine component of service programs, staff tend to employ highly structured clinical records, which ensure that certain "core" information is recorded about each appointment, or session in the program, while leaving open the option for individualized observations from the counsellor.

6.3 Why Is It Done: The Goals and Objectives of the Program

A statement of goals and objectives of the program should make clear the reason that the program is needed by the community, what you hope to achieve with the clients of the program, and why the program is structured the way it is in order to achieve those objectives.

Clearly, in programs for substance abusing youth, the principal goal of the intervention program will be the prevention or reduction of drug and alcohol use. However, in order to decide whether the goal has been attained, it is necessary to describe it much more objectively, e.g., in terms of a proportion of the clientele achieving a specified "successful" outcome, where the criterion of success is clearly and unambiguously stated.

Before continuing with this Unit, we would like you to do ACTIVITY 5.19 on page 5-82.

6.4 Measurable Objectives: Evaluating Outcomes

In order to be able to evaluate an intervention or program, you must be able to specify in advance what would constitute "success" of the program, and be able to measure attainment of that outcome. Measurable objectives are often phrased in terms of action words such as: to increase, to reduce, to develop, to establish, and so on. They indicate the goal of the activity.

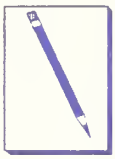
Suppose that you intended to implement a program with the stated objective: "to increase public awareness of adolescent alcohol and drug use through a public education campaign." To assess whether awareness was in fact increased, you would need to measure its level before the program was delivered and again afterwards. This would probably be a costly and complex operation. It might be more practical to have as your objective simply the delivery of the program, and some assessment of its value from the recipients. Though this may not be the ideal evaluation, it would be more feasible. Good evaluation can be practical, and involves setting criteria that are simple and readily verified.

Most programs for intervention on substance abuse have as their major objective that clients will be abstinent after the program, or will have reduced their level of drug use to non-hazardous levels. Again, the general objective is easy enough to understand, but in order for it to be measurable, you must specify what you mean by "abstinence" and "non-hazardous levels of use". One of the ways in which such terms can be made less ambiguous is to specify the time period to which the term applies, e.g. three weeks, or six months. Ambiguities about criteria are the major reason for the great variation found in the reported "rates of success" of various treatment programs. Pronouncements about "rates of success" that do not define their terms are worthless.

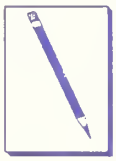
An additional difficult issue is defining "non-hazardous" levels of consumption. When dealing with adolescents, there is probably no non-hazardous level, since use of any non-prescribed psychotropics (except tobacco and caffeine) puts the user at risk of legal complications, to say the very least. However, many clients will significantly reduce their drug and alcohol use after participation in a treatment program. Although this may be construed as failure to reach the program's goal, it may nonetheless constitute a significant reduction of public health risk and as such is worthy of record in a good evaluation. Furthermore, a client might report greatly reduced drug use, and from his/her point of view have achieved a completely successful outcome from the program, although you may disagree with the interpretation. It is generally agreed that client satisfaction with the program is an important part of evaluation, and hence should be included in evaluations, disconcerting though they may be to many program staff.

Of course, most programs for treatment of substance abuse, particularly those for youthful clients, do not focus exclusively on drug use as the target of the intervention. Other areas of life functioning should be measured in the evaluation procedures for the program, and repeated at follow-up.

Finally, most programs have objectives concerning the number of clients that they expect to treat within a specified time period, and concerning the promptness with which requests for service are responded to. Goals in these areas should be specified in advance, and procedures for monitoring success in attaining those goals should be in place. Examples of specifiable program objectives can be found in the two articles by Lund (1978), and by Willer, Bartlett, and Northman (1978) in the bibliography at the end of this Unit.



To conclude this Unit, we would like you to do ACTIVITY 5.20 on page 5-83.



When you have completed ACTIVITY 5.20, please return to page 5-6 and tick off the learning objectives you have achieved in this Unit.

ACTIVITY 5.18

List the information that you are currently required to record:

1. about your clients

2. about your counselling activities (e.g. number of appointments kept or missed)

Think of the most important questions you would like to ask about client progress and outcomes and about the operation of the program. Could the information listed in 1 and 2 be used to enable you to answer these questions? If not, what would need to be added, and what could be deleted?

ACTIVITY 5.19

In terms of the type of counselling you normally do, isolate one particular type of intervention and answer the following questions about it, in order to prepare for evaluation.

- for whom is this intervention appropriate, i.e. for what type of client with what type of problem?
- what activities occur when you do the intervention?
- what is the rationale for using that particular intervention with that type of problem of your client?
- what is the expected outcome of the intervention, and how would you measure it?

ACTIVITY 5.20

Think of a client with whom you are working:

1. Develop a measurable objective based upon something the client considers very important to change about him/herself;

2. Specify the criteria you would use to measure achievement of this objective.

Now, think of the most important aspect of the overall service your program delivers. Specify a measurable objective for this aspect of the program, and indicate how one could verify achievement of this objective.

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APPENDIX:
CLIENT ACTIVITIES

GOAL ASSIGNMENT (use after ABC has been completed)

1. List the positive things you will lose by no longer having drugs to turn to.

2. List at least five changes you are going to have to make in your life in order to maintain your new drug use goals.

3. Identify at least three "goal areas" to work on over the next 2-3 weeks. These goal areas should be things that need to be worked on to help you stop using drugs. Think of your ABC's of drug use before making your selection.

ESTABLISHING ANTECEDENTS AND CONSEQUENCES

Specific questions and exercises may be used to help clients describe antecedents, behaviour and consequences in detail. Some ideas follow on the next six pages. The "typical day" exercise on pages 5-95 and 5-96 is particularly useful with a less insightful client, helping him/her "get inside" his/her drug-using behaviour.

1. Show your client the list of Antecedents attached. Ask him/her to identify at least 6-8 that apply to his/her drug and alcohol use.

2. Ask your client to name the 3-4 most powerful antecedents.

3. Ask him/her to rank the antecedents in order of priority.

4. Repeat steps 1 to 3 for the list of Consequences, also attached.

ANTECEDENTS

Emotions
- Feeling sad or depressed
- Feeling lonely
- Feeling anxious or tense
- Feeling frustrated or disappointed
- Feeling emotionally aroused
- Feeling helpless
- Feeling afraid
- Feeling upset by injustices and how rotten the world is
- Feeling angry
- Feeling good/happy, etc.
- Feeling bored.
- Other: _____

Social/Interpersonal
- When alone
- When asked to use drugs or drink by someone else/peer pressure
- When shy or inhibited
- When you're not able to express affection towards another
- When you're not able to express anger towards another
- Being taken advantage of
- A nagging spouse or friend
- When with an aggressive person
- When experiencing conflict or stress with someone else
- When wanting to increase your sexual urge or improve your sexual functioning
- When wanting to decrease or control sexual urges
- In a social situation or at a party
- Being with certain people
- Communication problems
- Other: _____

Physical
- Unable to sleep
- Experiencing withdrawal symptoms
- Wanting to feel mellow
- Wanting to feel high
- Wanting to experience a rush
- Feeling pain or physical discomfort (other than withdrawal)
- Sexual arousal/frustration
- When hungry
- When thirsty
- When having a lack of energy
- When having a headache
- Unable to stay awake
- Wanting to lose or gain weight
- Other: _____

Thoughts
- Unpleasant thoughts
- Fear of withdrawal
- "I'm no good" thoughts
- "Why did I act so stupidly" thoughts
- "I'll show him or her" thoughts
- "He (or she or they) can't tell me what to do" thoughts
- Guilt related thoughts
- Saying things to yourself to justify your drug/alcohol use
- Thinking about hang-ups
- Thinking about social problems
- Other: _____

Situation
- When not wanting to do anything
- Failing to accomplish a task or goal
- When faced with a difficult problem(s)
- Seeing or hearing alcohol advertisements
- Walking by a tavern
- Hearing references to drug taking or drinking
- Facing large responsibilities
- Having money
- Having alcohol or drugs
- Being in debt
- Being in a place where you often drink or take drugs
- Being in a tavern or restaurant
- Being in a friend's home
- While driving
- Being out-of-doors
- When your curiosity is aroused
- When engaging in pleasant events
- After using drugs once, or taking one drink
- When experiencing pressure from school or work
- A special occasion
- Having a meal
- Other: _____

CONSEQUENCES

Emotions
- Feel calmer or less upset
- Feel less bored
- Feel less depressed or sad
- Feel less nervous or anxious
- Feel brave or less inhibited
- Become very sensitive
- Feel happy or contented
- Other: _____

Social/Interpersonal
- Start conversations with friends and/or strangers
- Feel more comfortable in social situations
- More able to express feelings/laugh or talk more
- Communicate better/able to speak your mind
- Act sexy
- Gain attention and encouragement from friends
- Gain peer acceptance/approval
- Go along with others
- Defy or rebel against authorities
- You acted on your pro-drug attitudes
- Engage in sexual activities
- Avoid being with people or withdraw from activities
- Other: _____

Physical
- Relax
- Fall asleep
- Withdrawal symptoms are relieved or decreased
- Get "high" or "drunk"
- Experience a rush
- Pain is dulled/physical discomfort is relieved
- Eat less or eat more
- Thirst quenched
- Become thirsty
- Having more energy/feel wide awake
- Hangover relieved
- Experience increased or decreased sexual arousal
- Sexual response is decreased or increased
- Other: _____

Thoughts
- Forget about hang-ups
- Forget about your own problems/worry less
- Forget about social problems
- Escape or forget painful memories
- Think positively about self
- Think "I don't care" sorts of thoughts
- Think negative thoughts less often
- Increased concentration
- Improved memory
- Think "I'm in control"
- Other: _____

Situation
- Challenge social values
- Improve your work performance
- Get out of a rut
- Having an intense/exciting experience
- Enjoy music more
- More creative
- Have a sense of adventure/sense of drama
- Have a sense of risk and risk taking
- Problems seem or are resolved
- Expand own awareness/explore inner self
- Other: _____

ESTABLISHING A HISTORY OF DRUG-USING SITUATIONS

1. Under what circumstances did most of your substance use in the past year take place?

a) In social situations? (Specify) _____

_____

b) With peers? _____

_____

c) Time of day? _____

d) What were you thinking about? _____

_____

e) How were you feeling emotionally? _____

_____

f) How were you feeling physically? _____

_____

g) Where did you generally use? _____

_____

h) On which days of the week did you generally use? _____

_____

i) Are there any other factors related to your pattern of use?

_____

_____

continued →

CIRCUMSTANCES AND CONSEQUENCES

2. Describe the effect of each substance on the following: the way you talked to other people, maintaining social relationships, conflicts, aggression, confidence, stress, school performance, work performance, involvement in sexual activity, mood, risk-taking and involvement in illegal activities. (Use extra paper if necessary.)

SUBSTANCE #1 (SPECIFY): _____

_____

_____

SUBSTANCE #2 (SPECIFY): _____

_____

_____

SUBSTANCE #3 (SPECIFY): _____

_____

_____

3. Describe periods of controlled use or abstinence in the past year. Include influences that made it possible to control your use as well as situations in which you felt vulnerable to use or experienced excessive cravings.

SUBSTANCE #1 (SPECIFY): _____

_____

_____

SUBSTANCE #2 (SPECIFY): _____

_____

_____

SUBSTANCE #3 (SPECIFY): _____

_____

_____

ESTABLISHING ABC INFORMATION: YOUR TYPICAL DAY

1. Describe a typical weekday (Mon-Thurs) in your life. Begin with the time you wake up and list everything that you usually do throughout the day. Include each time you drink and use other drugs, and the amount for each use. Go through the day until you go to sleep.

   Example: I wake up around 10 o'clock. I take a shower. I drink a cup of coffee and smoke a joint. Then I get dressed and go to school. Etc.

2. Describe a typical weekend day (Fri-Sun) in your life. Again, begin with the time you wake up and end with falling asleep.

continued →

YOUR TYPICAL DAY (continued)

3. In a typical drug-using day:

a) What drugs and how much of each is used?

b) Where do you use each drug, and with whom?

c) How often during the day will you use, and when during the day does use occur?

d) What are 3 major triggers (antecedents) to your drug use?

e) What are 3 pay-offs (consequences) of your drug use?

RELAPSE ANALYSIS

Reflect on your drug use of last weekend/evening and answer the following questions. Be specific.

1. What were the triggers that led to this use? List as many as you can and rank them in order of most powerful to least powerful.

2. What strategies, techniques or skills did you try to use to counteract these triggers/cravings?

3. What steps in planning would have reduced the likelihood of this relapse?

4. What could you do differently to avoid using in the future? Outline specific strategies to deal with the triggers in #1 above.

5. What have you learned from this drug use?

RELAPSE PLANNING

1. Imagine a possible relapse situation, picturing where you are, who you are with and the drugs you are using.

2. Imagine the thoughts and feelings that you may be having about the relapse. Write down your thoughts and feelings.

3. For each thought or feeling write down a more constructive thought or feeling which can help you to overcome the relapse.

4. Identify people you could talk to or places you could go that would help you to get out of the relapse.

5. Make a step-by-step plan of what you will do to end the relapse — i.e. what you will say to others who are with you, what you will do, where you will go.

SELF-MONITORING RECORD

ANTECEDENTS Situation, Thought, Feeling, Physical, People, Activity	BEHAVIOUR CRAVE REFUSE					CONSEQUENCES Example: Thought, Feeling, Behaviour, Social, Physical
	DATE	TIME	USE	DRUG	QUANTITY	

STRATEGIES TO AVOID DRUG USE AND STOP CRAVINGS			
DATE	TIME	STRATEGY	RATE EFFECTIVENESS 1 to 5 Not at All - 1 Very Effective - 5

PROFILE OF PROBLEM SOLVING SKILLS/DEFICITS

Yes ☐ No ☐ can define problems clearly and concisely,

Yes ☐ No ☐ can accept personal responsibility for problems,

Yes ☐ No ☐ can prioritize problems,

Yes ☐ No ☐ can generate a range of alternative solutions,

Yes ☐ No ☐ will seek and accept input from others,

Yes ☐ No ☐ can evaluate each alternative solution by considering the pros and cons,

Yes ☐ No ☐ will decide on the best possible solution,

Yes ☐ No ☐ will implement the solution,

Yes ☐ No ☐ can evaluate the outcome of the solution,

Yes ☐ No ☐ will try another solution if the desired outcome is not achieved.

HELPFUL THINKING MONITOR

TIME/DATE SITUATION	UNHELPFUL THOUGHTS	HELPFUL REPLACEMENT THOUGHTS	OUTCOME

E.G.

TIME/DATE	UNHELPFUL	POSSIBLE REPLACEMENT THOUGHT	OUTCOME
8:15 P.M. Saturday beer commercial	"Everybody uses"	"Everyone doesn't use. The commercials on T.V. are to get more people to use."	Stopped thinking about using. Called a friend who does not use.

HELPFUL THINKING ASSIGNMENT

1. List 2-3 strategies you will use to help increase your helpful thinking.

2. How will each of these strategies help you to stay drug and alcohol free?

3. Monitor your use of each of these strategies and write down the outcome. Do this every day.

HELPFUL THINKING MONITOR

TIME/DATE SITUATION	UNHELPFUL THOUGHTS	HELPFUL REPLACEMENT THOUGHTS	OUTCOME

SETTING INDIVIDUAL ASSERTIVE GOALS

In the chart below, put an "X" to indicate how assertive you are in each of the 15 behaviour areas. Circle the numbers of the behaviours that you want to change.

	NON-ASSERTIVE				ASSERTIVE			AGGRESSIVE			
	0	1	2	3	4	5	6	7	8	9	10
1. turning down requests											
2. expressing personal limitations such as admitting ignorance in some areas											
3. meeting new people, arranging to see people again											
4. expressing positive feelings or praise											
5. handling criticism											
6. differing with others											
7. assertion with employer, professor, supervisor, or another person with authority											
8. giving negative feedback or criticism											
9. handling/accepting compliments or praise											
10. speaking your mind about other people											
11. making yourself comfortable in social situations											
12. speaking up in groups											
13. confronting others											
14. starting conversations											
15. expressing unhappiness, frustration, humiliation, etc.											

PERSONAL TENSION PROFILE

Do you experience any of the following symptoms? If so, how often?

	Check One: Never	Daily	Weekly	Monthly
Headaches (migraine, sinus, tension)				
Difficulty falling asleep				
Stomach pain or problem (tightness, "butterflies", gas, heartburn)				
Difficulty concentrating				
Easily irritated				
Uncomfortable breathing (shallow, rapid)				
Sweating excessively				

How much of your alcohol/drug use is a way of dealing with stressful feelings (being uptight, afraid, frustrated or "down")? Circle the appropriate number.

none **one-quarter** **one-half** **three-quarters** **all**

What other ways do you have of dealing with stressful feelings? Please list.

_____

_____

Have you had any previous experience with relaxation techniques, yoga or meditation?

Yes ☐ **No** ☐

If yes, please explain: _____

How many hours do you sleep a night? _____ hours.

How many caffeine drinks (tea, coffee, cola) do you drink a day? _____ cups.

Do you often feel very tired? **Yes** ☐ **No** ☐

How many cigarettes do you smoke a day? _____ packs.

Have you ever had ulcers? **Yes** ☐ **No** ☐

Have you ever had low back pain? **Yes** ☐ **No** ☐

Have you ever had asthma? **Yes** ☐ **No** ☐

Rate the way you feel now on this 10 point scale:

1 Totally relaxed 2 3 4 5 6 Moderately tense 7 8 9 10 Extremely tense

Which of the following areas cause you tension or give you hassles? Circle the appropriate ones:

Self family home friends school work authority other

TENSION DIARY

NAME: _____

DATE	What did you do to decrease your stress/tension level? or What made you feel good today?	What increased your stress/tension level?